MENTAL HYGIENE

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THE AIMS OF PSYCHIATRY*

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THE subject of psychiatry is to be presented here as an orientation course for workers in closely allied fields, such as medicine, psychology, sociology, social service, and so forth. Psychiatry is being called upon more and more in these various fields, which are all concerned with human nature and its vagaries. This being so, the claims, criticisms, and speculations concerning psychiatry call for careful consideration. The literal meaning of psychiatry is *treatment of the psyche.* Derangement of the mind or psyche is manifested through behavior, whether expressed in words or in actions. The mentally deranged person is not a happy one, if we except those individuals who have so lost grasp of reality that they live entirely in a world of phantasy. But even in the case of these latter, death or mutilation by accident, starvation, or infection would be the outcome if they were not cared for by relatives or friends, whose unhappiness is not to be measured or expressed in words. Psychiatry, then, becomes the art of restoring the person to his natural relationships with his environment.

Psychiatry is an art. Every art rests upon a foundation of science, and to the extent to which the basic knowledge is organizable and transmissible, the art may be called an applied science. To what extent is it possible to transmit from one person to another the knowledge that is necessary for the successful treatment of the mentally deranged? This

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is a very difficult question to answer, but it must be faced, so that we can know our limitations and strive for improvement.

There are certain principles in psychiatry that can be formulated and transmitted verbally to the student. The same is true of surgery. But the ability to recognize the situation to which the rules apply, and to act deftly and effectively, is a skill born only of experience, whether in psychiatry or surgery. Advances in physiology and in mental analysis are gradually reducing to law and order more and more of the psychiatric phenomena, and thus diminishing the field in which the doctor must rely upon the intuitive crystallization of past experience. But at the present time there is nothing that will take the place of experience in a great many of the situations that develop, and it is probable that we shall never be able to eliminate a certain irreducible minimum of experience, no matter how well we formulate the science underlying psychiatry.

Psychiatry deals with two large groups of cases:

1. The frank psychoses, including schizophrenia, manic-depressive psychosis, arteriosclerotic and alcoholic psychoses, toxic states of various kinds, general paralysis of the insane, epileptic psychoses, and degenerative changes like Pick's disease and Alzheimer's disease and others.

2. The so-called psychoneuroses, milder behavior deviations in a way, yet often very disabling. They include hysteria, morbid compulsions and tensions, psychic invalidism, sexual deviations and incapacities, and the so-called neurasthenias.

Is there any connection between the two groups? That is, can we point to any radical difference in the process which produces a psychosis and that which appears merely as a psychoneurosis, or is it possible for a psychoneurosis to merge gradually into a psychosis? That there is a close connection seems evident, both from longitudinal studies of individual cases and from analyses of family trees.

I remember, in this connection, the case of a woman whose pre-psychotic personality was excellent. She was very energetic, had made an unusual success as a teacher, was also an excellent housekeeper and cook, and though rather sensitive to hurts, never blamed others for her troubles. Her physical health began to suffer a few years after her marriage, and

finally a severe throat infection, with gastric and renal involvements, resulted in a toxic psychosis, for which she was admitted to a psychiatric hospital. She recovered completely, but was readmitted soon thereafter with a diagnosis of hysteria. She was discharged, and for the next two years, though living at home with her husband and running the house in a satisfactory way, she was fatiguable and rather ill at ease at times with strangers. After an attack of influenza, there was increased irritability, increased eroticism, and a tendency to be self-conscious about it and to take to herself any remarks that might be made in her presence. She returned to the hospital for two months, and was discharged with a diagnosis of psychoneurosis, neurasthenia. So far, apparently, there had not been anything sufficiently bizarre in her behavior to justify a diagnosis of schizophrenia. Six months later, however, she was readmitted with auditory hallucinations and delusions which made the diagnosis of schizophrenic episode seem proper. She was discharged in a little over a year. Two years later she was again admitted, and this time a diagnosis of dementia precox was made. She heard voices accusing her of sexual crimes, and on the basis of these hallucinations she attacked physicians, nurses, and other patients. She blamed her obscene talk and behavior upon the voices, and she was very indignant about it; she could not accept the fact that these ideas originated in her own mind. She made no improvement in this respect, though she was neat in her person and did excellent work in arts and crafts. She was finally transferred to a state hospital, unimproved.

In the case of this woman, the symptoms that appeared after her first, apparently toxic, psychosis were such that they gave the impression of psychoneurosis. Looking back over the case, it is of course easy enough to say that schizophrenia should have been diagnosed from the beginning; but when was the beginning? Thousands of psychoneurotics never develop a psychosis. Psychiatry, at present, has no answer to the question: "Why do some become psychotic, and others not?" any more than medicine has an answer to the question: "Why, considering the widespread incidence of tuberculous infection, do relatively few persons develop clinical tuberculosis?" We can often influence the course of tuberculosis favorably by the proper régime; we can do the

same with psychoses. In the case of both afflictions, we often fail; and in the case of both, we are ignorant of the fundamental failure to cope with the reality, whether it be the germ of tuberculosis or the stresses of human relationships.

In contrast to the above case, I wish to cite that of a professional woman, Miss Q., who, in her forties, has made a recovery from a case of dementia precox which began in her twenties and kept her in hospitals seventeen years.

There were no psychoses in the family stock, which was unusually intelligent and successful. One sibling, however, was considered a neurasthenic.

The patient was the oldest of four children. Her development was normal, and she was bright, interesting, the delight of her family. Once she had made up her mind, she was rather firm and rigid, but she was cheerful and happy, singing all day long. She was very frank, perhaps a little too much so in talking about her home affairs outside, suggesting a somewhat immature judgment. Generous and considerate, she took a normal amount of responsibility, and was perhaps a little too serious about her work. After graduation from college at twenty-one, she turned more and more to her career and less to her old friends. Although receiving much attention from men, she seemed indifferent to them. From childhood she was devoted to her father, whose personality was very congenial to hers.

One day, when she was twenty-nine years old, she said to her mother, "I don't know whether I am crazy or not." This startling announcement followed a long walk she had taken with a woman for whom she felt a deep affection. That night the patient was restless, wanted to give away all her money, and talked about things that had happened in her childhood. She said that her father had made her undress before him, which was untrue.

She became so distressed and disturbed that she had to be sent to a hospital, then to a second, and finally to a third, in which she remained fourteen years. At the time of her admission to the first hospital, her facial expression was dull, and she seemed apathetic. She lay in bed, covering her head, refusing to speak. Then she would suddenly get up, dance about the room, whistling, singing, laughing in a silly way, and assuming bizarre attitudes. She was negativistic, ex-

posed herself unconventionally, had to be restrained from running around. On admission to the last hospital, she was passive, taking no part in her own care. Her hands and feet were cyanotic and clammy. There were differences in the knee jerk, plantar reaction, and abdominal reflex on the two sides. Her replies to questions seemed irrelevant most of the time:

Q. How would you describe your feelings?

A. Sometimes I wonder how much there is in that expression, "Silence gives consent."

Q. Are you sensitive? Do you feel things keenly?

A. I suppose you know about growing and all things like that, don't you? I wonder if it is possible to make a cat grow into the size of a lion. I just want to know, because I have one, and haven't seen it for a long time. I did not want to do any harm.

Q. Why did you make it necessary for us to carry you into the hospital?

A. It is possible and well to notice very closely before one describes things.

Some of the answers seemed to show some realization of illness:

A. Why, I was going back part of the time and when I came to, some of the time my tongue was going and talking and my mind seemed to be 'way, 'way back, don't you know, as if I could not catch up to my tongue, but thank goodness, I did catch up.

Q. Were you excited?

A. Well, I suppose it certainly was, but you see that was such a horror to any one, it certainly was to me, to find that when I came to again, after those times with my speech—now for instance, suppose I had not known all the time while I was speaking to you, after I talked—and so I was in such horror to think that I had been speaking words, that I did not know what I had said.

Q. Do you know what you talked about?

A. Any lie, I think, away back in childhood, things I saw that did not happen at all, things on my tongue, although about the first thing I said, I think, when I was a child, was a lie. I reformed for good afterwards. Some of the time the words did not come plainly. Then when they did come plainly, why, I think they did not come rightly some of the time.

Her course from this time on was variable. Sometimes she was neat and orderly; in other phases of her course she refused to wear clothes and draped herself in a sheet. At one time, she was beating her head and abdomen severely. Gradually, her manner became stiff, formal. She wore old-fashioned clothes, refusing modern ones. She then passed into a phase of rather pointless, though conventional gossip,

in a monotonous voice. It was felt that her turbulent period was over, but that she was arrested on a very inadequate, deteriorated level, though one which permitted her to present a conventional appearance, except for the conspicuously outmoded clothes she wore.

Finally she was provided with an apartment outside the hospital, with a nurse. At first she was suspicious, stubborn, and difficult. Her improvement was gradual, however, and finally she has been able to establish her own menage and has reëntered her former field of activity, where she has won public recognition and is doing excellent work. Her commitment has been voided, and she has been discharged in her own custody. Diagnosis: dementia praecox, catatonic type.

We have said that the aim of psychiatry is to restore the individual to normal relationships with his environment. That includes the preservation of normal relationships between the individuals of the group. This aim of psychiatry will remain a pious wish and little more unless we can learn some, if not all, of the factors that conspire to bring about a psychosis or a psychoneurosis. In the case of tuberculosis, we have learned some of the factors that cause the illness—the bacillus itself, overexertion, lack of proper food. We have learned, further, the value of certain artificial maneuvers, such as resting a lung by pneumothorax and encouraging the healing of osteal and other forms of tuberculosis by ultraviolet light. But prevention of infection is a sort of flight from reality, based upon a realization that the patient "can't take it," to use a current idiom; and the other parts of the treatment are very indirect attacks upon the problem. Nevertheless, these methods have revolutionized our attitude toward the Great White Plague.

Psychiatry, at present, finds itself in very much the same situation. Experience seems to indicate that there are personality make-ups so stable that almost no amount of unfortunate life experience, in childhood or later, will suffice to produce a serious deviation from normal human relationships; and, on the other hand, that there are constitutions so susceptible, or inherently so unstable, that no amount of care and protection will prevent a final failure. The immune group is probably small, and the susceptible group includes some of society's most valuable people. The psychiatrist

must accept the human material as it comes to him, and try to compensate, by skillful handling, for the imperfections of nature.

That there is a relationship between temperament and physical constitution is an observation as old as recorded history. But it is only lately that the correlations have been scientifically arranged and emphasized by such men as Kretschmer, Pende, Draper, and others. That the tendency to psychosis and psychoneurosis runs in families has long been a popular belief, and modern investigations have substantiated it, while refining and amplifying the concept. It has taken much longer to work out the inheritance laws of susceptibility to psychosis than it has in the case of simple dominants, like Huntington's chorea, or even recessives, like albinism. This indicates that the factors are more complex, and the work done so far bears this out, while leaving no doubt that there are hereditary elements in mental derangement.

In the case of schizophrenia in Europe it has been found, for instance, that if one parent is schizophrenic, 10 per cent of the children will have schizophrenia, which is over ten times the normal expectancy; and 35 per cent of the children will have schizoid personalities.[1] If both parents are schizophrenic, half of the children will have the disease, and only one-fifth will be normal. The genetics of this problem is by no means understood completely; various hypotheses are advanced, providing for the presence of two recessive genes, or a combination of recessive and dominant characters, or the effect of heterozygous make-up in a dominant. Laws may conceivably be formulated some day to explain the appearance of psychoses on an hereditary basis in every instance. But a simpler and, to my mind, more probable explanation of the difficulty encountered in studies of heredity is that, with a given constitutional make-up, the occurrence of psychosis or psychoneurosis depends upon certain enviromental factors as yet not well understood.

In regard to manic-depressive psychoses, the observations —on European material in this case also—are as follows:

If one parent is manic-depressive, one-third of the children

[1] See *Praktische Ergebnisse der psychiatrischen Erblichkeitsforschung*, by E. Rüdin. *Naturwissenschaften*, Vol. 18, pp. 273–80, March 28, 1930.

will have the disease, and an additional one-sixth will be subject to mood swings.

If both parents have the disease, two-thirds of the children will have it, and one-third will have milder mood disorders.

These figures, as they stand, suggest the mathematical perfection of Mendelian protocols. The reality, however, is by no means so simple. We cannot be sure that the one-third or the two-thirds stand for definite individuals, instead of for merely a mathematical average, the result of chance environmental influences upon a constitutional basis. It is to be hoped that further work will provide the answer to this question.[1]

In regard to the psychoneuroses, the problem of heredity is even more difficult, largely because of the vagueness of the clinical classifications. It has been found, however, that in such cases there is a high familial incidence of psychoses and suicide.[2] Here again the environmental factor complicates the situation and cannot be disregarded. If one belongs to a family in which there have been cases of this kind, has grown up in it and been exposed to the tensions prevailing in it, and is conscious of the nature of the family stock, would this in itself excite morbid fears and attitudes that might appear as psychoneuroses? The answer to this question is by no means obvious, though it may eventually be obtained by the correlation of data derived by careful studies, statistical and individual.

The morbid symptoms of psychoneurosis must not be confused with a natural concern, or worry, or sadness, emotions which almost every one has experienced at times; yet the exact point at which an emotion becomes "morbid" is not easy to fix. Hence the aims and duties of psychiatry are also hard to delimit. It is safer to say that psychiatry aims to maintain or to restore a happy relationship between the individual and his environment. Does this statement of the case seem simplistic, unscientific, lacking in substance? Then what shall we say instead? Perhaps that psychiatry must

[1] See "A Contribution to the Problem of Heredity Among Schizophrenics," by Manfred Bleuler (*Journal of Nervous and Mental Disease*, Vol. 74, pp. 393–467, October, 1931). See also "Inheritance of Mental Disorders," by Aubrey Lewis, M.D., in *Chances of Morbid Inheritance*, edited by C. P. Blacker. Baltimore: William Wood and Company, 1934. pp. 86–133.

[2] Lewis, *loc. cit.*

seek to bring the patient to a realization of reality? But is that enough? For what is reality? We are born, with pain to our mothers; we survive, thanks to constant care, work, and sacrifice on the part of our parents or guardians; we grow up and compete for the goods of the world with others, and consider ourselves lucky if we can get more of them than they can; we beget children and worry over them and work for them, or we don't have children and feel that life is not complete; we suffer ill health; and finally we die. That is reality. Millions cling to this reality, which is life, not for any logical reason, but because to them there is something more than the bare "reality"—their attitude toward it has invested it with a feeling which softens its rough outlines and brightens its dull facets. We call this attitude toward life normal; it is complementary to the primitive instinct to live, which is present in all living things; it is the neopallial corollary to the vital function of the brain stem. This complementary function can fail and so even endanger the primitive life instinct. Are there not cases of dogs who have starved themselves to death, refusing all food, when their masters have died? Certainly human beings have so died for loss of love. The remedy there is certainly not an introduction to "reality," but rather an emotional reorientation that will reinvest reality with attractive colors.

Let us now consider the problem of function versus structure. It has become the custom to designate as *functional* certain psychoses occurring in individuals in whose brains no pathological lesions could be demonstrated with the microscope and the available staining technique. These psychoses were in contrast to those in which anatomical changes could be shown and which were called *organic.* In the former group fall dementia praecox, or the schizophrenias, and manic-depressive psychosis, as well as the psychoneuroses; in the latter (organic) group are placed senile psychosis, general paralysis of the insane, arteriosclerotic brain disease, toxic psychoses, alcoholic or Korsakow's psychosis, and so forth. Such a criterion of functional versus organic is of course rather in the nature of a convenience, or perhaps of a therapeutic implication, than a reality.

As an example of the fallacy involved, take the difference in the temperaments of two different breeds or strains of that

highly organized animal, the horse—the Percheron, heavy, strong, quiet, amiable, easily managed, and the Morgan, fiery, highly reactive, requiring careful management, and easily "spoiled," or, to use anthropomorphic terminology, easily made into an asocial individual. If we examine the nervous systems of two such horses, what is there under the microscope to distinguish one from the other? And if we extend our investigation with our present technique to the endocrine glands, or to any other tissue of the body, are we any the wiser? Yet no one doubts that the temperaments of the two horses are characteristics that are bred into them and that are typical of their race.

It is, of course, absurd to think of changes in function without some change in the physical basis for that function; otherwise we should have to accept some mystical *animus* that merely used the brain as its organ of expression. Such an animus may be a convenient concept, but it need not be mystical, any more than is the electric charge in a condenser. The human body with its brain, like any machine, is subject to the same physical laws as the rest of the material world. But the *integration* of the physical phenomena gives a result as new and autonomous as a chemical compound. The living thing differs from a machine, also, in having the capacity to alter the internal relationships of its nervous system as a result of the vicissitudes to which it is exposed. An inanimate machine cannot alter its external function or internal organization unless controlled or directed by human design. A motor depends, for its smooth functioning, upon a fixed relation between its timing gear and the valves. Although every part be perfect, if one alters that relationship, the motor will run either badly or not at all. Such a change in the internal relationships of the motor might properly be called a functional one, since the parts themselves remain intact.

It is with some such analogy as this in mind that one must think of the so-called "functional" changes in the human personality. Certainly, if I have learned, through experience of the proper stimuli, to jerk my hand away when I hear a bell ring, there have occurred certain physical changes in my brain which have altered the relationships—or the pattern, if you prefer—of a number, or possibly all, of the neurones that I possess. These changes, whatever they may be, are so

infinitely more complex and subtle than the simple relations of the timing gear in the motor that the analogy is almost ridiculous. What is the nature of the change? Nobody knows. Could it be, after all, some time relationship, such as that characteristic of changes in chronaxy?[1] I ask the question with a smile, and expect no answer now. If we place the brain in an electric circuit with an oscillograph, we find rhythmical discharges coming from the brain cells when the subject is at rest, with his eyes closed; and we find that the solution of a problem in mental arithmetic causes an immediate and striking change in the pattern of these discharges.[2]

Suffice it to say: Man is a machine, but a machine that shares with all living matter the marvelous property of internal modification by experience. This internal modification is, unfortunately, not accessible to anatomical investigation, any more than is the presence of an electrical charge in a condenser, but such modifications of pattern have been established experimentally, both in man and animals. These internal modifications usually have a survival value; they move the animal toward what is good for it, and away from what is bad. Even the lowly Stentor can discriminate: it will at first accept inedible carmine grains as if they were food, but will soon cease to do so, and will reject those it has taken. With Pavlov's work you are, of course, all familiar. He conditioned his dogs to make very fine discriminations, with food as the incentive. But when the discrimination became too difficult, there was trouble. The dog had a nervous breakdown, refused to attempt any discriminations at all, and had to be given a complete rest for several months.[3] Similar reactions have been reported in sheep.[4]

Can a similar process be at work in human beings who become psychoneurotic or psychotic? The human brain, that

[1] See "Relation Between Binet Mental Age and Motor Chronaxia," by George Kreezer and Katherine P. Bradway. *Archives of Neurology and Psychiatry*, Vol. 34, pp. 1149–71, December, 1935.

[2] See "The Electric-Encephalogram in Epilepsy and in Conditions of Impaired Consciousness," by F. A. Gibbs, M.D., H. Davis, M.D., and W. G. Lennox, M.D. *Archives of Neurology and Psychiatry*, Vol. 34, pp. 1133–48, December, 1935.

[3] See *Conditioned Reflexes*, by I. P. Pavlov. New York: Oxford University Press, 1927. pp. 290–91.

[4] See "Effect of Extract of Adrenal Cortex on Experimental Neurosis in Sheep," by H. S. Liddell, O. D. Anderson, E. Kotyuka, and F. A. Hartman. *Archives of Neurology and Psychiatry*, Vol. 34, pp. 973–93, November, 1935.

"hypertrophied cephalic segment," so much more complex than the dog's, sheep's, or even the chimpanzee's, is no doubt capable of much greater elaboration, both for good and for evil. Now, compared with the case of the animal, the demands of civilized life on man are subtly and cruelly exacting; the fine discriminations demanded of him are innumerable and difficult. He must, first of all, love his parents. Both his natural inclinations and public opinion oblige him to do this. Yet he must emancipate himself from his parents, very often without any encouragement from them; on the contrary they are rather apt to cling to him emotionally. Furthermore, the boy, while attached to his mother by physical ties intensified by ideational overtones of a strength unknown to the lower animals, has to inhibit certain sexual reactions to her which are the natural concomitants of his attachment. The same situation exists between the girl and the father, though for the girl the problem may be more complex, due to the fact that, like the boy, she has also had an intimate dependence upon her mother for nourishment and early care.

Furthermore, the child, as he grows up, must inhibit his natural tendencies to acquire the things he wants by direct action; yet he must maintain his capacity and zest for competitive struggle for the goods of this world, in which struggle he must draw a line of hairlike fineness between what is moral and what is immoral or "wrong." And although he must acquire property and wealth, if possible, he must also be altruistic, generous, noble. He must be constantly exposed to sex stimulation through visual, aural, and olfactory channels, and he must take a manly interest in the other sex in order to be acceptable socially, yet he must remain continent, or find his sexual outlets under a cloud of such conflicting rules, traditions, and emotions that the light of reason never penetrates. He must have strong drives, be aggressive and alert, yet conceal these drives as much as possible. He must have a deep respect for the truth, yet learn to suppress, deny, or distort it on innumerable occasions. On such foundations does our civilazation rest. If a man cannot make these fine distinctions, he is called a "rigid personality", and it seems to be true that such personalities are more liable to mental or emotional derangement. Rigidity, indicating strength in mathematics, thus becomes weakness in life. Perhaps that is

why great mathematicians are so often sensitive, introverted, or schizoid personalities.

These inhibitions and fine distinctions would probably not be so dangerous to mental tranquillity if they were more directly imposed from without, instead of asserting themselves very indirectly from within, through what used to be called, in old-fashioned terms, the conscience, but which it is now fashionable to call the super-ego. If an army officer appears at a soldier's tent door and orders him to get up immediately, make his bed, clean his tent, and do a dozen other odd jobs, it is very easy for the soldier to comply. But if it is the luckless doughboy's conscience that tells him to do these things, the chances are strong that he will struggle with himself a long time before he goes into action. The stimulus in the first case was so direct and unequivocal that there was no room for conflict. Furthermore, the soldier could swear, *sotto voce,* at the officer; which was much more conducive to his internal unity than swearing at himself.

For the animal, life is much more simple in all the relationships mentioned. Emancipation from the parents may be unpleasant, but it is unequivocal: the mother bites, kicks, scratches, or pushes the youngster out of the nest. The animal meets no demand for altruism, except what is instinctive to it. Its sex life is more or less periodic, and limited only by the refusal of the female or the resentment of another stronger male; there are no self-reproaches. The animal need not conceal the truth, nor pretend about the state of his emotions.

There is much evidence, in psychiatric practice, of the appropriateness of Christ's words, recorded by St. Mark: "If a house be divided against itself, that house cannot stand." The division in the case of many of our patients seems to occur between the conscience, or super-ego, and the instinctive drives. Which element in this conflict is the more to blame, it is hard to say; there are presumably variations in the strength of the instinctual drives in different people, just as there are in general vigor and vitality. It seems evident, however, that more internal mischief comes from a morbid conscience than from an excessive instinctual drive, or id, (as Freud's translator has dubbed it, from the German *das Es*). Mischief is here meant as referring to the per-

sonality itself; the mischief that can be done externally by the uncontrolled or distorted instincts is too obvious to require mention. Furthermore, it seems that in some people, not only is the conscience too unbiological in its make-up, but it so pervades the mental apparatus that even insignificant or irrelevant acts are inhibited, or, obversely, are stimulated. This seems to explain the senseless phobias and the equally senseless compulsions that we meet. The reason why certain acts rather than others are avoided or executed is answered by the psychoanalysts in terms of the symbolic significance of those acts. Certainly, almost all of the bizarre acts we see can be explained in that way, if we wish to do so; whether the explanation is the proper one is very difficult to determine, but perhaps that will be established beyond doubt in the course of time.

To the psychoanalytic eye, the schizophrenias are full of symbolism, as are all the psychoses, the psychoneuroses, and even the "pathology" of everyday life.[1] That this should be so, is not surprising, since much of our normal activity consists of communicating with each other, and all communication depends upon symbols, whether of word, look, or gesture. This symbolizing capacity is the most characteristic thing about the human brain, as opposed to that of the lower animals, and is responsible for its great advantage in abstract reasoning. The significant thing is that psychopathic symbols are esoteric, peculiar to the patient himself, not understandable by others. In fact, more often than not, they are not understandable to the patient either. It is evident that the relation of these symbolic acts and phobias to the original inhibiting factors can no longer be expressed by the patient in the current, generally accepted word symbols or even pictorial images; they are inaccessible to verbal expression. This characteristic they share with a very large part of the cerebral activity, which is never completely verbalizable.

The existence of such an activity, and its importance for that part of the mind which can be expressed in words, was pointed out as far back as 1886, according to William James, and there was much discussion of the rôle of this "subliminal

[1] See Collected Papers of Sigmund Freud, especially *Dream Analysis* and *Three Contributions to the Psychology of Sex*. New York: International Psychoanalytic Press, 1924–25.

consciousness." Whatever the dynamics of this irradiation of inhibition or impulse may be, it is characteristic of the psychoses and psychoneuroses, where it occurs to a degree that is conspicuous or even incapacitating and dangerous. That it occurs in so-called normal people to a lesser degree is probable. Let him who is without sin cast the first stone! A few days ago, in the course of a conversation, the manager of an airport said with justifiable pride that because of their conservative policy and careful supervision, they had as yet had no serious accident. But as soon as he had said this, he laughed a little sheepishly, turned away, and walked several yards to the nearest house, where he reached up to the wooden signboard and touched it ceremoniously, saying, "I guess I better knock wood after that one." That was not a joke, but the expression of a real need or "compulsion" in his personality, though one common to a great many people in our particular culture.

A compulsive thought may be the only recognizable symptom in a patient who is otherwise quite normal in the conduct of his daily life. The thought may seem alien to him, and may annoy him greatly, so that at length he seeks help to rid himself of it. A man, for example, who was treated recently by one of my colleagues was greatly annoyed by thoughts of putting out the eyes of people, of defecating on them, and of cutting off their arms. To most people, such thoughts, while not pleasant, would not be persistent enough to be annoying. But they haunted this man, like avenging furies. For several months he talked about them, in all their ramifications, to the psychiatrist. It is a pleasure to record that finally he was able to trace these unwelcome thoughts to their source, and gradually ceased to suffer from them.[1] It seemed that they were robbed of their potency when he could express them freely. The outcome is not always so fortunate.

Such a condition, in which only a small part of the personality seems to be involved, leaving the rest apparently intact, is called a part reaction, or, in the terminology of Dr. Adolf Meyer, a merergasia.

It is well to point out here that the classification of mental diseases is very unsatisfactory. It is in a state comparable to the classifications of "tubercle" before the bacillus was

[1] Case cited in a personal communication from Dr. James H. Wall.

known, or of "croup" before diphtheria and other invaders of the throat were recognized. Since we cannot be sure of the etiology, our classifications must be clinical and descriptive. The result is that we see symptoms belonging to more than one of the classifications in the same patient at the same time, and we have to fall back upon a sort of combined diagnosis, classifying the disease in one division, with the addition of symptoms from another. Dr. Adolf Meyer's terminology lends itself to this. It is purely descriptive, and while it groups symptoms under appropriate headings, the meanings of which appear in the term used, it is as flexible as any combination of symptoms may require.[1]

It was not until late in the eighteenth century that some sort of order began to be made of the psychoses. Dementia paralytica was distinguished, although it was not until in the twentieth century that the rôle of the treponema of syphilis was conclusively proved. Pinel, whose book describing his observations and innovations at the asylum of Bicêtre I wish to recommend earnestly to your attention, made an attempt at a classification which was useful and reasonable, and based entirely on objective observation.[2] Pinel's merit, of course, does not lie in his classifications, but in his enunciation and practical proof of the importance of humane and sensible management based upon the study of the peculiarities of each *individual* patient.

The greatest nosologist of all in the psychiatric field was Kraepelin. It was he who first singled out the difference between those "milder" forms of psychosis in which recovery was the rule, at least for the individual attack, and the "severe" forms which developed into a "secondary dementia" or "secondary paranoia." He found certain symptoms in the latter group that were not present in the former. The former group represents the manic-depressive group, and the latter received the name of dementia praecox, the term based upon Kraepelin's observation that the onset was usually about puberty and the course usually one that ended in dementia.

[1] See "British Influences in Psychiatry and Mental Hygiene," by Adolf Meyer, M.D. Fourteenth Mandsley Lecture. *Journal of Mental Science*, Vol. 79, July, 1933. p. 454.

[2] *A Treatise on Insanity*, by Philippe Pinel. Translated from the French by D. D. Davies, M.D. London: Cadell and Davies, 1806.

Further observation and analysis showed, however, that the symptoms characteristic of Kraepelin's dementia praecox occurred in cases that were different in their onset and course, and that did not always progress to dementia, but showed more or less complete recovery or at least arrest. For these reasons Bleuler thought best to enlarge the group, and to attach to it the name *schizophrenia,* or rather *schizophrenias,* since he was not at all sure that the symptoms he observed were characteristic of a single disease entity. He chose the word schizophrenia, because it embodied the most characteristic symptom as he saw it—namely, the splitting or shattering of the associative mechanism, with the result of bizarre and irrelevant actions and speech. About this group, Bleuler says: "This disease may come to a standstill at any stage and many of its symptoms may clear up, very much or altogether; but if it progresses, it leads to a dementia of a definite character."[1] The case I quoted at some length, of the woman who was seventeen years in hospitals, illustrates the irrelevance of association, the peculiar affect, the bizarre behavior, and the possibility of recovery in a case of schizophrenia.

The other major group of the so-called functional psychoses, that of the manic-depressive disorders, is characterized by a profound disturbance of mood; either great depression of spirits, with retardation of thought and motility and suicidal tendencies, or else great elation of spirits and overactivity; rapid thought and speech, so rapid that the listener can often not keep up with it; flight of ideas based upon very superficial associations; punning; singing; and mischievousness or maliciousness. The content of thought is not characteristic; the depressed person may be self-accusatory, and express feelings of guilt and worthlessness, or he may be irritable and suspicious. So, also, the elated person may be gay, lighthearted, apparently enjoying himself, or he may be quarrelsome, irritable, suspicious, or capricious in his attitude. Although a tendency to periodic mood swings is characteristic of the manic-depressive patient, it is a fact that there are about as many manic-depressive cases with only one state-hospital admission as there are with several.

[1] *Dementia Praecox oder Gruppe der Schizophrenien,* by Eugen Bleuler, M.D. In *Handbuch der Psychiatrie,* edited by Aschaffenburg. Leipzig: Franz Deuticke, 1911.

Of the organic psychoses there are many. Alcohol, arteriosclerosis, syphilis, degenerative processes like Pick's disease and Alzheimer's disease, the psychosis of Huntington's chorea, toxic states due to malnutrition, dehydration, somatic diseases, and drugs—these are some of the organic types. It is extremely important to remember—and this cannot be stressed too strongly—that toxic states are often superimposed on the so-called functional disorders,[1] thus disguising their real nature; also, that a toxic state in a vulnerable personality may give symptoms of a functional psychosis, but of briefer duration.[2]

The psychoneuroses form a large and very important group. In a way, they are more important than the psychoses, because they afflict so very many people, and because they are so intimately interwoven with everyday life. The distortion that characterizes the psychoneurotic view of life enters into countless situations in the workaday world, and involves thousands of people in its effects. It is here that the broad scope of psychiatry becomes obvious. When does so-called "normal" fear, worry, aggressiveness, ambition, or activity become abnormal?

A great change has taken place during the past fifty years in the attitude of the general public toward the problems of the mind. The mind is looked upon less reverently, but more understandingly. Perhaps this has grown naturally out of the concept of evolution. We feel greater kinship with the other animals. There is less of the mysterious soul and more of reaction to stimulus, more following of instinct, more psychobiological integration and adjustment or maladjustment to the group. We are more critical both of our heroes and of our villains. We see mechanisms where we formerly saw inspirations from Heaven or Hell. We are more conscious of the rationalizations employed by our leaders to justify their unconsciously motivated designs, whether in business or in politics. Many tragedies of national and international scope

[1] See "Toxic States as Complications in Functional Psychoses; Etiology and Treatment," by G. R. Jameison, M.D., and J. H. Wall, M.D. *Psychiatric Quarterly*, Vol. 4, pp. 263–76, April, 1930.

[2] See "Some Psychiatric Aspects of Physical Diseases," by G. R. Jameison, M.D. (*New York State Journal of Medicine*, Vol. 35, pp. 660–68, July, 1935), and "Some Psychiatric Aspects of Marijuana Intoxication," by P. H. Drewry, M.D. (*Psychiatric Quarterly*, Vol. 10, pp. 232–42, April, 1936).

spring from the same blind, unrecognized personality distortions that in lesser settings ruin the lives of individuals and their families. The blind spots, overcompensations, transferred hatreds, and projections of statesmen, diplomats, and generals are no different in genesis from those of the obscure citizen, but their capacity for harm is multiplied by the degree of power wielded by those in whom they operate. It is the function of psychiatry, in its management of the whole personality, to make itself felt in this sphere also, to the end that the personal problems of the few shall not become tragedy for the many.

The psychiatrist is concerned with the total individual as an integrated phenomenon, in his relations to other individuals. In that capacity, the psychiatrist becomes a sort of clearing house for data concerning all the part functions of his patient. These data will come from various specialists, when and as they are needed. The gastroenterologist, the oculist, the urologist, the gynecologist, the psychologist, in short, all the specialists may be called upon for help. It is the duty of the psychiatrist to weigh the relative importance of each of these contributions, to fit them together into a harmonious whole, and to guide the treatment accordingly. To do this, the psychiatrist must have a knowledge of the human organism both in the medical and the psychological sense, must have the point of view of the coördinator and the spirit of the disinterested and incorruptible friend, so that with growing experience, he may become more and more useful to his fellow men in their personal relationships.

SUMMARY

Psychiatry deals with all the problems of human personality in school, business, and society in general. It is an art, resting on a still developing science, and still largely dependent on the psychiatrist's personality and the personal relationship he establishes with the patient. The nosology of personality deviations is in an unsatisfactory and fluid state. Division into "organic" and "functional" is convenient, but inexact. A descriptive terminology that states the facts is more flexible and less misleading. Troubles of behavior come from a disturbance of the psychobiological integration, into which enter many factors in every case.

There is certainly a relationship between temperament and physical make-up, whether in man or horse, and studies in heredity are important, though they may give us averages rather than individuals, susceptibilities rather than predestinations. Realities of life may seem intolerable either for external or internal reasons. The neopallium may revolt against the brain stem.

The living machine is unique in having the ability to change its internal organization according to environment. This "conditioning" is of great importance in human relationships. But the demands of human society for close conditioning are severe beyond anything the lower animal meets; and the more "rigid" the personality, the more susceptible to breakdown.

A conscience that is too unbiological and rigid may cause internal mischief and may inhibit certain normal activities or give rise to certain bizarre acts or thoughts because of their symbolic significance, a significance inaccessible to verbal expression by the patient.

The psychoneuroses and part-psychopathies, though "milder" personality deviations than the psychoses, are probably an even greater danger to society and its individual members, since psychoneurotic mechanisms in the leaders of nations may plunge whole peoples into misery, and operating in the people themselves, may give a morbid tone to the social structure.

The psychiatrist must see the whole personality as a phenomenon of emergent integration, and must understand the elements of this integration as well as the total phenomenon. He must help the patient discover a reinterpretation of reality and of himself.

THE PLACE OF CLINICAL PSYCHOLOGY IN MENTAL HYGIENE*

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IN SPEAKING to you to-night, I take it that I represent clinical psychology, while you are representatives of mental hygiene. It would be a brave man—or a foolhardy one—who would undertake to speak for all clinical psychologists, because there are wide variations in their interests and beliefs. On your side I expect that each of you has his own personal answer to the question, "What is mental hygiene?" With such vaguely delimited fields to deal with, it will be seen that my task is not a simple one.

With your permission I shall first attempt to describe or to define clinical psychology. Some forty years ago Lightner Witmer, of the University of Pennsylvania, had the pregnant idea that the laboratory methods and results of the psychology of that day might be usefully applied to the problems daily exhibited by children in their school, play, home, or other activities. To-day this appears obvious—but significant ideas are always obvious once some one has expressed them. Following his idea, Dr. Witmer started to examine children at the University of Pennsylvania laboratory. If we are to judge from the papers published from that laboratory and in the organ of that clinic, *The Psychological Clinic*—and it seems perfectly fair to do so—interest centered largely on problems of academic adjustments. Retardation and promotion, the health of the school child, special-subject problems, and the like were the chief concern of this organization, at least during its earliest days. And this field of academic-adjustment problems is still one of the major fields of interest of the clinical psychologist.

Now to retell briefly another familiar story. At the turn of the century Binet was engaged to devise a scheme of pick-

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ing the dullards in the Parisian schools. Note, again it was an educational need. Binet's accomplishments are familiar to all of you, but here it is pertinent to recall who introduced his tests in America and in what connection. H. H. Goddard, so the story goes, brought the 1908 scale to this country and translated it for use at the Vineland Training School. Even in this early crude form the new instrument proved its worth because of its evident value in classifying the inmates of that institution. Thus we introduce two further aspects of clinical psychology: first, activity in the field of mental deficiency, and second, a methodological contribution that has come to be the tail which too frequently wags the dog—mental testing or psychometrics.

In the latter part of the first decade of the century, Dr. William Healy—this time a psychiatrist, but one with a psychological background—introduced this sort of applied psychology into a new field. He established a psychopathic laboratory in connection with the Cook County Juvenile Court. This, I believe, can be taken as the beginning of clinical psychological attention to the problems of delinquency and crime.

Within the last two decades the mental-hygiene movement itself has fostered one of the special fields for clinical psychology which I feel is of greater importance than any other. That is the program of child guidance so notably supported by the Commonwealth Fund.

Here, then, are four fields in which clinical psychology has value—education, mental deficiency, crime and delinquency, and child guidance. There are other fields—for example, industry, vocational guidance, family welfare, in all of which clinical psychology may have a very definite place. An enumeration such as this shows where clinical psychology has been used; it serves to orientate this activity.

As a more formal basis for discussion, we may quote the statement formulated by a committee of the Clinical Section of the American Psychological Association.[1] This definition

[1] "The Definition of Clinical Psychology and Standards of Training for Clinical Psychologists." Report of Committee of Clinical Section of American Psychological Association. *The Psychological Clinic*, Vol. 23, pp. 2–8, January–June, 1935.

reads: "Clinical psychology is a form of applied psychology which aims to define the behavior capacities and behavior characteristics of an individual through methods of measurement, analysis, and observation; and which, on a basis of an integration of these findings with data secured from the physical examinations and social histories, gives suggestions and recommendations for the proper adjustment of that individual." In order to describe the work of clinical psychology, we shall consider separately the various parts of this definition.

One of the professional tasks of the clinical psychologist is to define behavior capacities. We need not be concerned here with theoretical questions concerning the nature of intelligence, talents, skills, or other abilities. It is sufficient to say that any of these traits is defined by what the individual can do and by that alone. In order to quantify what he can do, we have developed tests and scales without end. It is one of the jobs of the clinical psychologist to be able to use at the proper time and place the proper test. And what is of far greater importance, it is necessary for him to interpret the results of such tests. Teachers, social workers, physicians, ministers, even intelligent high-school seniors can give practically any intelligence test if they are willing to spend a little time in developing suitable skills. In fact, in many ways skill in typewriting is more difficult to develop than skill in administering a Binet test. A skilled X-ray technician can take beautiful pictures, but no physician would be content with the technician's interpretation. The stenographer may secure an excellent social history, but the agency would seldom rely upon her interpretation. So it is in clinical mental testing: administering the test is a relatively simple skill, but interpretation requires insight based upon technical training and experience. It is for this, among other things, that the clinical psychologist is trained. Note that I have been careful to say "among other things." All too frequently educators, social workers, physicians, yes, even psychologists consider clinical psychology to be nothing more than mental testing. This is, of course, an entirely erroneous notion, which can be blamed, I believe, entirely on the psychologists themselves. The professional skill of any one who can be

considered a clinical psychologist must go beyond clinical psychometrics.

The second skill required, according to the statement quoted, is that relating to the definition of behavior characteristics. Now what does this mean? Twenty years ago Walter E. Fernald wrote: "The writer once assembled in a room 252 individuals with a mental age of 8 years. The individuals in this group varied in physical age from twelve to fifty years. Some of them had learned to read, while others had not been able to do so. Some were capable of elementary computations, while others found the simplest concept of numbers almost beyond their capacity. We had been able to develop some of them to become fairly expert mechanics, but others were able to do only the simplest sort of manual labor. Some were conscientious and relatively trustworthy; others were most untruthful, dishonest, and unmoral. In some, sex proclivities seemed to be the dominant interest while in others the sex interest seemed to be entirely normal. This variability shows that a measurable intellectual level is not the only factor in the study of the feebleminded and in the working out the type of care and training that they need."[1] Neither is a measurable intellectual level the only factor in the behavioral study of individuals who are not feebleminded. Similar behavior capacities do not guarantee similar behavior characteristics.

You are all familiar with the boy whose I.Q. is 110, but who is retarded a year in school and is failing in his work even at that; or with children of average ability who exhibit all sorts of behavior that is disturbing to the family; or with shy, retiring children of all levels of ability. More specifically we may define behavior characteristics as those ways of behaving which we observe as mannerisms, peculiar habits, emotionally toned acts, compensatory behavior, and so on. A person's complexes, mechanisms, inhibitions, compulsions, phobias, obsessions, and so on are all part of the total picture of his behavior characteristics. In short, we describe his behavior characteristics by an exposition of the details of

[1] *Standarized Fields of Inquiry for Clinical Studies of Border-line Defectives*, by Walter E. Fernald, M.D. MENTAL HYGIENE, Vol. 1, pp. 211–34, April, 1917.

his behavior plus an interpretive account of why he behaves in just that way.

There are some among you, I am sure, who will question whether the description of behavior characteristics, especially those that concern the so-called emotional life, is the professional job of the clinical psychologist. I should expect such a question from the members of the medical profession and especially from the psychiatrist. In answer I would say that such characteristics are unquestionably acquired ways of behaving—that is, they are learned reactions. At least they are products of experience, which is merely a broad connotation of learning. The study of learning and its products, in broad or narrow connotation, has always been one of the tasks of scientific psychology. I am sure that all, including the members of the medical profession, will agree that the medical curriculum does not afford sufficient content to make the physician any more capable of dealing with the technical problems of psychology than is any intelligent layman. This comment does not apply with equal force to the psychiatric specialist because his training is weighted more heavily in the direction of psychology. But even here the psychology is all too frequently one-sided and limited.

The third task of the clinical psychologist, after describing behavior capacities and characteristics, is to integrate his purely psychological findings with those of two groups of professional colleagues. From the physician he must secure the record of the patient's physical condition. Correctible physical disabilities must be treated by the medical specialist before anything can be done about behavior. If the physical disability cannot be corrected, it must be treated as a constant factor which will exercise a very definite function in the individual's total adjustment. For the social history of the case, the psychologist must turn to the social case-worker. Securing such history is as much a specialized technical task as is making a physical examination, and, like the physical examination, it should be in the hands of a person with the proper professional training.

Thus far the tasks have been related to examination, interpretation, and the formulation of an hypothesis or conclusion

—in short, these tasks are diagnostic. Before we go further, it may be well to call attention to the greatest weakness in the whole field of dealing with behavioral problems of whatever nature. That weakness is the complete lack of a professional curriculum designed to train people to do the complete job that we have thus far been describing under the term "clinical psychology." As has already been pointed out, the medical curriculum does not allow even a bare minimum of necessary psychological training, and it allows even less contact with social work. The professional training of the social worker includes almost as little psychology and less of medicine. Some of you may now be expecting me to say that the professional curriculum of the clinical psychologist is the best available at present. But I should deny that most emphatically. There is no commonly accepted curriculum for the clinical psychologist. If we assume the minimum requirement of a Master's degree, then even this minimum is strong on psychology. But unless there has been careful guidance of the student's program, there may be little if any training in the other two fields. Even if we consider the usual maximum of a Ph.D degree, there are very few graduate schools that would allow a student to follow a program leading to a professional as distinct from a research or teaching degree.

As I see it, the problems of behavior are basically psychological. True, behavior, of humans at least, is dependent upon both the biological organism and the social milieu. Therefore, a proper training for dealing with problem behavior or the guidance of behavior requires subject matter from both the physical or medical and the social-work fields. This is not the place to outline even a tentative curriculum. A subcommittee of the White House Conference suggested that the physician might get a *little* additional work in psychology, but this the psychologist would reject as inadequate. Perhaps a year of graduate work in psychology, with the necessary undergraduate prerequisites in addition to the M.D. degree, would be partially satisfactory. On the other hand, it might be suggested that the psychologist get a limited amount of medicine—for example, didactic work in clinical neurology, pediatrics, medicine, and a year's clinical work in these same

fields. But I am afraid the medical profession would oppose this as impossible. In spite of the apparent difficulties in the way of developing a suitable curriculum, it is my feeling that it must be done if we are ever to have a properly trained professional group to deal with behavior problems.

In addition to diagnosis, it is the task of clinical psychology to make recommendations directed toward a more satisfactory adjustment of the individual. When we speak of adjustment, we may mean either or both of two things. One is adjustment to society and the other we might call adjustment to one's self. Problems of the second sort of adjustment are commonly called personality problems, although they are frequently significant factors in the etiology of maladjustments to society. In either case we are dealing with behavior about which some one is concerned or about which some one complains.

Undesirable behavior about which there is concern or complaint may roughly be grouped into four classes. In the first class would be behavior which is the direct concomitant of physical condition—*e.g.*, paralyses, chorea, the epilepsies, or abnormal behavior due to malnutrition, infection, injury, and so on. Such problems are emphatically and categorically medical. Any attempt to deal with this problem behavior is futile until there is correction of the physical disability. Here the psychologist has a very minor rôle, if he has any at all.

A second type of problem behavior is due to deficient intelligence. Here medicine may be of importance in establishing etiology—for example, in respect to endocrinological or neurological factors which may be of importance in certain types of feebleminded persons. However, with the knowledge at present available, medical science can do little to ameliorate the condition. Help for the subnormal individual can come only through training for adaptation to a simple environment. Desirable training programs depend upon classification based upon psychological testing methods, and are carried out by the psychologically determined educational methods. In this field the rôle of the clinical psychologist is an important one, as is also that of the properly trained teacher.

The third type of problem in our present crude classifica-

tion is that characterized by behavior patterns which are socially unacceptable. These are frequently referred to as "conduct" problems. Such behavior may of course be related to either of the first two classes, but in such cases those problems are primary. When neither physical disability nor subnormal intelligence is a factor in the situation, then conduct problems may be behavior patterns learned or acquired directly from interactions with the social environment. In such cases the discovery of reasons for the behavior and plans for its correction are quite definitely psychological.

The fourth class of problems includes those usually designated by the adjective "personality." These are problems of lack of integration, or lack of control, or lack of direction of the affective elements of personality. Such disturbances may be indicated by observable behavior which is socially disturbing—that is, by conduct problems—or they may be manifest in withdrawal, or self-accusatory, or inadequate behavior.

It is with this fourth group of problems that modern dynamic psychiatry is concerned. Unlike most scientific contributions, the discovery of the significance of behavior dynamics must be attributed largely to one man. That man is, of course, the Austrian physician, Sigmund Freud. All of the psychological and psychiatric theories that behavior is the resultant of dynamic interplay between organism and environment owe their very existence to the effect that psychoanalysis has had on psychological thinking. This debt that we owe to Freud does not obligate us, however, to accept the details of his theory. In fact, psychologists themselves have originated theoretical frameworks for the description of behavior that are more scientifically acceptable. Behaviorism, with its basic principles in the physiological aspect of behavior, has had an important influence. To-day, however, we recognize the serious limitations of this systematic position. The organismic interactionalism of J. R. Kantor is felt by those who know it to be the most complete explanatory system for dealing with behavior. This position may be stated—perhaps too simply—thus: A person's interaction with any immediate stimulus situation is affected by all of his previous interactions with men, things, and relations. We can understand behavior—including problem behavior—only by coördinating the individual's experiential history with the

present stimulus situation. It seems to me that the various psychoanalytic schools, and much psychiatric thought, tend to neglect the present situation and to rely too greatly upon past experience, or even upon pre-behavioral forces, such as the libido or the id, for explanation. On the other hand, the topological psychology, notably of Lewin, appears frequently to neglect the reactional biography and to overemphasize the dynamics of the immediate situation.

I seem to have digressed from my discussion of so-called personality problems. But the digression serves to indicate that these problems are just as much a concern of psychology as are any of the other types. The clinical psychologist, therefore, has as important a rôle in dealing with these problems as he has in dealing with those that are due to intellectual lacks or to habit training.

Before attempting to summarize the discussion of the nature of clinical psychology, a word should be said about the adjective, "clinical." Literally, of course, "clinical" refers to the bed, and in its ecclesiastical and early medical usage was limited to the meaning of "bedside." To-day, in medicine at least, the connotations are much broader. The patients attending an out-patient clinic are *ipso facto* not confined to bed. In modern usage, "clinical" refers to a point of view; it is a type of methodology. In contrast to the scientific method, which is designed to discover generalizations of natural phenomena, the clinical method seeks to discover generalizations concerning the particular case. The procedures of the two methods are analogous—in each there is observation of events, the recording of data, the formulation of hypotheses, the testing of the hypotheses, and the final formulation of a law, theory, or diagnosis. There is, of course, no reason in etymology or logic for a restriction of the term "clinical" to the field of medicine.

We have earlier quoted a definition which holds that the task of clinical psychology is to "define behavior capacities and behavior characteristics of the individual." The all-important differentiating term here is "individual." Tests for measuring behavior capacities are widely used in industry and in education, but in these connections the concern is with groups of individuals and not with any specific one. Sociologists and anthropologists describe the behavior char-

acteristics of a tribal group, or of a community, but here again the concern is with the group and not with a specific individual. The public-health official integrates physical and social findings to the end of better community health. The economist makes recommendations concerning changes in human behavior to the end of possibly better social adjustment. It is thus evident that the separate tasks enumerated for the clinical psychologist are not in themselves differential. Only when these tasks relate to an individual can one use the term "clinical," and this is true whether the clinician is a physician, a dentist, a surgeon, or a psychologist.

We may now take stock of our discussion. The logical position of clinical psychology may be stated in five points:

1. Human psychology—and here we are not concerned with any other kind—is the scientific study of human behavior. It must be noted here that the modern tendency in psychology is away from the behavior of an isolated organism and in the direction of the organism's—*i.e.*, the psychological personality's—behavior in interaction with its environment.

2. Any sort of behavior, normal or abnormal, usual or unusual, good or bad, individual or group, is a legitimate field for psychological study.

3. The data and principles of psychology may be applied as are the data and principles of any science.

4. One application of such data and principles is to the behavior of an individual to the end of guiding that individual to satisfactory adjustment or of correcting an existing unsatisfactory adjustment. This is the field of clinical psychology.

5. Lastly, it must be pointed out that no science can be applied to practical affairs in an unadulterated state. The problems of human behavior involve biological and social factors, so that efforts at dealing with such problems must be based upon contributions from all three fields—biology, sociology, and psychology. Thus is introduced a difficulty which has already been hinted at and to which we shall return.

Having tried to describe the field that I represent, as I conceive it to be, I shall now endeavor to answer the question, "What is mental hygiene?" If we look in the dictionary, we find that the term hygiene "relates to the preservation of health." It follows that mental hygiene must refer to the

preservation of mental health. In its turn preservation means "to maintain intact or unimpaired." This essentially implies prevention of the undesirable—in the present instance prevention of mental ill health, or mental abnormality.

To illustrate the agreement in emphasis on the connotation of preservation, or more specifically on prevention, we may quote the definitions given by three men in different professions. Dr. William S. Sadler, a psychiatrist, says: "Mental hygiene is the most important factor in all the domain of present-day preventive medicine."[1] Dr. Harry N. Rivlin, an educationist, says: "Mental hygiene is the attempt to reduce the prevalence of mental illness or emotional maladjustment by pointing the way to the development of habits conducive to good mental health."[2] Thirdly, we may quote a psychologist, Dr. L. F. Shaffer, who says: "Mental hygiene refers to the prevention of inadequate adjustments and to the processes by which maladjusted persons are restored to normal living."[3] It should be noticed that each of these writers emphasizes the idea of prevention; only the last includes also the idea of cure. If one reads Dr. Shaffer's book, it is evident that he is not thinking of cure of the extremes of maladjustment, but rather of the correction of the beginning stages of maladjustment; and cure of early stages is an aspect of prevention.

A word must also be said about the adjective, "mental." This has caused more difficulties than a six-letter word has any right to. The present-day psychiatrist or psychologist looks with disdain on the savage witch-doctor's efforts at therapy by appeasing spirits; we laugh at the practice of anointing the weapon instead of the wound; we have no patience with faith cures which deal with the soul. Yet many, if not most, modern clinicians, after observing a patient's behavior and learning his history, immediately relate the symptoms to an entity as mysterious as any of those mentioned, which they call the mind. Historically, we find the following three principles used to account for abnormalities

[1] *Theory and Practice of Psychiatry*, by William S. Sadler, M.D. St. Louis: C. V. Mosby Company, 1936.

[2] *Educating for Adjustment*, by Harry N. Rivlin. New York: D. Appleton-Century Company, 1936.

[3] *The Psychology of Adjustment*, by L. F. Shaffer. Boston: Houghton Mifflin Company, 1936.

in behavior: external spirits, internal soul, and mind. From the point of view of science, all these must be rejected because, if for no other reason, they violate the rule of parsimony—they are entities not required for satisfactory explanation. We must discard the term "mental" when it denotes the extra-scientific entity, mind. Our problem is to deal with behavior as we can observe it. If "mental" is made equivalent to "behavioral," we can use it; if there is danger of the traditional meaning slipping in to confuse issues, we had better avoid it.

Perhaps all of you will accept the essentials of the proposed definition that mental hygiene is a field of endeavor the purpose of which is the prevention of behavior abnormalities. Probably each of you would, however, read into this definition a slightly different meaning. These different colorings would reflect your differing interests.

This is shown by a little investigation which I undertook as part of the preparation of this paper. It seemed a reasonable assumption that the field of mental hygiene might be defined inductively by an analysis of what people write about as mental hygiene. At first I planned to classify the papers that had appeared in five or ten volumes of MENTAL HYGIENE, the official journal of the movement. After listing the papers in the latest available bound volume of this journal, I found that each one practically formed a class in itself. There were papers on alcoholism, feeblemindedness, statistics of psychoses, family adjustments, mental hygiene in the nursery school and in industry, religion in mental hygiene, and so on through a long list. But there were scarcely two papers that dealt with the same topic.

This result was discouraging for the plan I had in mind—which was not the present one—so I tried an analysis of the papers presented at the First International Congress on Mental Hygiene. According to the program of this Congress, there were sixty papers, excluding those presented under the auspices of some affiliated association. Of these sixty, fourteen were general in nature, concerning the field of mental hygiene and its significance; five dealt with the organization of communities and clinics; four each with delinquency, the family, and education; three each with the psychopath and

the neurotic, mental hospitals, and the pre-school child; two each with public health, superior abilities, and social relations; one each with non-hospital care of mental patients, feeblemindedness, vocational guidance, teacher training, parent education, and with the mental-hygiene aspects of alcohol, syphilis, genetics, industry, dependency, the crippled child, religion, and recreation.

Such a list is imposing in its variety. The fifty-odd national associations affiliated with the Congress represented social work, medicine (including public health), neurology, psychiatry, hospital management, criminology, education, child welfare, industrial management, sociology, psychology, philosophy, law, religion, nursing, eugenics, occupational therapy, and the specialized fields of study of mental deficiency and epilepsy. From such a survey as this it is evident that the interests of those who are associated with mental hygiene comprise a large section of human activity. This is, of course, as it should be, but it makes the mental-hygiene movement very definitely a general, not a specific one.

This list also indicates that in carrying on its task of the preservation of mental or behavioral normalities mental hygiene leaves no stone unturned. In its full extension, mental hygiene has both a public and a personal aspect, as does physical hygiene. As public health is concerned with the control of physical factors of the environment in order to improve sanitary conditions, prevent epidemics, regulate water supplies, and so on, so mental hygiene has a public mental-health problem in the control of social environmental conditions, in order to reduce the problems of social pathology, which are frequently of great significance in the behavior difficulties of individuals.

In many respects, and particularly from the point of view of psychology, the personal aspect of mental hygiene is of greater importance than the public. Personal mental hygiene is concerned with the environmental factors that directly affect the development of the personality. Thus it is interested in parent education as a means of securing more suitable family and parent-child relations. It helps the teacher understand her children and their problems, and, of equal importance, it helps her in her own adjustments. In a

still more personal way it affords guidance to every individual in integrating his or her own experiences into a stable, unitary personality.

The specific method of carrying out any of the various related tasks of mental hygiene is the problem of some special professional group. For example, social work concerns itself with those problems of human behavior which result in social pathology. The criminologist is concerned with that sort of social pathology which is evident in antisocial acts or crime and delinquency. The educator has the opportunity of guiding the school child or the high-school adolescent in his educational program, his vocational aims, and his social and personal adjustments. The minister or priest is a useful member of the mental-hygiene family because of his technical skill and familiarity with the spiritual values, so frequently of great importance in adjustment. In those extreme deviations of behavior evidenced by loss of contact with reality (the psychoses), or in that sort characterized by a lack of, or a breakdown of, personality integration (the psychoneuroses), and in those deviations that are immediately conditioned by neurological or other physical disabilities, the neuropsychiatrist finds his field of service. In a similar way we could mention each of the several professional groups that have an interest in the whole program of mental hygiene and show what its contribution is.

It is, however, our particular task to place clinical psychology in this program. Earlier this evening I tried to describe the task of clinical psychology as I see it. Essentially this task is the application of certain psychological data and principles to the problems of human behavior. In some ways I personally feel that, while such applications can be made and have a value at any age, they are of greatest value and significance in childhood and adolescence. Those aspects of clinical psychology that have to do with guidance, educational, vocational, or personal, have definite value at any age. Those that are concerned with the alleviation of behavior difficulties are more valuable at the earlier ages. If one considers the flexibility, the fluidity, the developability of the child, it is easy to see why this is so. Therefore, if we think of the task of mental hygiene as the preservation of mental health and the prevention of mental ill health, then the chief

contribution of clinical psychology to this program is its work of helping the child to make adequate social and personal adjustments.

That last sentence was an excellent stopping place, but there is one further point that I feel should be made. That point is this: "In the practical clinic situation, just how far can the clinician go in readjusting the problem behavior, particularly of the child?"

We have already pointed out that the psycho-clinician must turn to the physician and to the social worker for the physical and social histories respectively. He must also go to the educator for the always important school history. Thus, even the examination and diagnosis cannot be complete without the coöperation of other professional groups.

This is even more true when we consider the problems of handling, correction, psycho-pedagogy, treatment, guidance, therapy—call it what you will. In cases of mental deficiency, it is manifestly impossible for the clinician to handle the patient directly. He must rely upon a special school or institution, with specially trained teachers to help the child make his adjustment. I have seen many cases of those very disturbing problems of the home in which I felt sure that very definite improvement would be evident if I could have the child live with me for a period. While I might arrange that for one case, I cannot do it with many. Therefore, I must depend upon parental reëducation and coöperation, or upon a social agency that will find a suitable home for the child. Frequently the nature of the problem requires close medical supervision or even therapy. In such cases one must turn to the physician for treatment. If the psycho-clinician is also a physician, this latter possibility is provided for. But no man can hope to carry on all the specialized functions of the physician, the psychologist, the teacher, the social worker, and the father confessor.

Therefore, I believe that the best way of dealing with the field of behavior problems, at present at least, is by close and harmonious coöperation between different professional groups. This coöperation can probably be best secured by a type of organization such as that used in the demonstration child-guidance clinics supported by the Commonwealth Fund.

This brings us again to the question of professional train-

ing for this particular task. Perhaps the future will see a specially developed curriculum, which I personally hope will come to pass. For the present we must get the task done with the professionally trained people that are available. In this connection I should like to read a paragraph from a letter of Dr. Leo Kanner's commenting upon a recent textbook. He says: "I consider it [the textbook] as another hopeful indication of the disappearance of previous agitations about competencies and strict delimitations of the functions of pediatricians, psychologists, psychiatrists, educators, social workers, parents, and even neurologists and theologians, all of whom claim that they alone should handle behavior problems of children. To my mind the question is not, 'Who should handle these difficulties?' but 'To what extent is any particular individual competent to handle these problems?' "

CRIME AND ADOLESCENCE*

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THE topic assigned to me appears to be an enticing one. No doubt about the large number of adolescent boys and girls confined in various reform schools; no doubt either that these young offenders are by far the largest source from which adult criminals are recruited. One of my patient-criminals once remarked that 85 per cent of the young offenders confined in reform schools follow afterward the path of crime, and that "the rest are not worth a damn anyway." There would seem, therefore, to be a very close relationship between crime and adolescence.

And yet, as a clinician trained to tracing disease to its ultimate rather than its superficial sources, I have an inner resistance against treating the topic as given, for it implies, on the one hand, that the roots of criminal behavior lie in adolescence and, on the other hand, that crime is a type of human behavior very precisely and distinctly separated from the rest of human behavior. I challenge both these statements. In medicine we are aware of the fact that precipitating causes are not coeval with etiological factors, and that the obvious appearance of disease at a certain period or even on a certain day does not at all indicate that that is the day or period on which it began. For, quite universally, diseases are preceded by an incubation period. You may find that the measle rash on a child appeared on May 16, but the disease was no doubt contracted perhaps several weeks before. In mental diseases the incubation period is much longer even when the disease breaks out acutely, and it certainly is of greater duration in the more chronic forms. It has now become an axiom with us that in aberrant psychic behavior the causes ultimately leading to such behavior have been long in operation—not only for months, but for years. I submit,

* Read before the First Institute of the Child Adjustment Clinic, Washington, D. C., May 16, 1936.

therefore, that it is not possible to speak of adolescence as a stage in which crime finds its first expression, but rather that we have to go to the earliest stages of the child's development in order to uncover the true period in which the antisocial behavior began and the subsequent period in which it further developed.

I further challenge the conception of crime generally held by the layman—namely, the purely legalistic view that makes conviction and imprisonment synonymous with crime. We know better than that now; we know that not every convict duly sentenced and imprisoned is necessarily criminal, and we certainly are aware of the fact that there are many criminals who escape conviction and imprisonment. And this includes not only those who, if apprehended and tried, would by all odds be convicted and sentenced, but those whose criminal behavior is what I should call "marginal"; that is to say, those individuals who technically comply with the law, but are nevertheless actually breaking it. Then again, we have the very large number of people, especially in business life, who do not hesitate to resort to every trick possible. Though in a sense these are sanctioned by the prevailing public code, yet from the standpoint of the higher conceptions of social relationship, they are certainly antisocial, if not even technically criminal.

I should, therefore, like to speak of crime as a piece of aberrant social behavior that goes against the better interests of society as developed by society's best elements. Such a conception would have to include an ethical and moral code of which the legalistic and even the sociologic trend take no cognizance. Thus conceived, it would be very difficult to say where proper social behavior ends and antisocial behavior begins, and equally where antisocial behavior imperceptibly shades into behavior that obviously cannot be recognized as anything but criminal. The difficulty apparently is the same as that encountered in drawing a distinction between normal behavior and behavior that is neurotically conditioned.

Coming now to the problem under discussion, we have to go into the question of the etiological factors in crime and the age at which they begin to operate. Just as you would expect a jurist to delineate the etiological factors in terms of law

and a sociologist in terms of mass social relations, so naturally you would expect a psychiatrist to look for the causes of antisocial behavior in the emotional environment in which the individual lives and with which he is surrounded. It is at this point that you will perceive why I resent the implication that crime begins in adolescence. For emotional problems begin to confront the individual from a very early age—nay, at the time of his birth. Why, then, would it not be natural to assume that criminality also begins at birth—not, mind you, actual criminal behavior, but its direct *anlage*—since normal behavior and neuroses also begin here? Freud has surprised us by submitting that the difficulties which appear in later life can be traced to early life situations. Rank has out-Freuded Freud, submitting that the separation of the child from the mother is in itself the original and fruitful source of anxiety, the primary trauma, as it were; that is, the source of all the anxiety with which the individual is likely to react in later life. Knowing by this time that criminal behavior is essentially a reaction which is expressive of certain abnormal emotional constellations, we have reason to suppose, assuming that there is some truth in Rank's conception, that the nucleus of criminal behavior may also be traced to the time of birth. However, I doubt very much whether any one of us would be willing to accept this conception; for even if it has some truth in it, it would be an exceedingly difficult matter to prove.

We are to some extent in a better position when we come to the next period that is filled with emotional significance—namely, weaning. Some children show a strong and often very acute emotional reaction to weaning. In the life history of some neurotics we often find that this has been a factor of considerable emotional significance in later life; and if this is true for neurotics, why indeed may it not be true for criminals, since criminality is often an expression of emotional difficulties of which the individual is wholly unconscious and which are, therefore, essentially neurotic in nature?

From weaning throughout infancy until the child goes to school, we have a period of life on which dynamic psychiatry lays particular stress. It is regarded as the formative period of life, determining all subsequent behavior. As it deter-

mines normal human behavior as well as neurotic behavior, it must of necessity determine criminal behavior; for normal behavior imperceptibly passes on the one hand into neurotic behavior and on the other hand into criminal behavior. The intimate analysis of criminals has found the student invariably confronted with material that unequivocally points to early childhood as the period during which criminal behavior begins. One has to go intimately into the life of the family group, the emotional relations existing between various members of the family, the various rivalries and jealousies, concealed hate and love reactions, and so on.

I have been especially impressed at this point with broken-home situations as fruitful etiological factors in crime, but here again I use the term "broken-home situations" in a technical psychiatric sense and not at all in a sociological sense. The sociologists have long pointed out that criminal offenders often come from broken homes, but they have never been able to explain those many exceptions in which the home was evidently not broken and yet developed in a child distinct criminal tendencies. Here we submit that a broken-home situation need not be considered in the sociological sense, as when one of the parents has left the home or when the child for reasons of its own leaves the home. Paradoxical as it may seem, one sometimes finds homes that are not at all broken in the accepted physical or material sense, yet that are broken from the standpoint of a particular boy or girl. If the boy has been neglected, if strong feelings of inferiority have been allowed to develop, if for some reason or other he is given to feel—regardless of how the feeling may have come about, or how unjustified it may be from the standpoint of the family—that it is not his home, then, though it may be entirely intact physically and materially and socially, it is a broken home so far as he is concerned; and after all his behavior is determined much more by what he feels than by what others feel about his situation. Such a conception requires a much more intimate investigation of the emotional problems of the child than has heretofore been possible by non-psychiatric and non-psychoanalytic methods.

From all this you will readily see and understand why I have taken issue with the topic as given. I do not feel that

there is any more direct relation between crime as determined social behavior and adolescence as a particular period of life than there is between crime and childhood behavior or even infant behavior.

Much or little may be said about childhood proper and its relation to the development of criminal behavior, but for our purpose it suffices merely to point out that it either continues such antisocial behavior as may have begun earlier, or may in itself lay the foundation for such behavior. Quite often criminal behavior in childhood has for its motivation some antipathic emotion that in itself has arisen out of refused love; equally often one is surprised to find that the antisocial behavior is more or less in the nature of an enactment of a vivid phantasy formation.

Several years ago, a number of robberies in my immediate neighborhood were traced to the operations of a group of youngsters who banded themselves together under the name of "The Al Capone Gang." This was at the height of the latter's fame or notoriety. Where one is dealing with antipathic emotions as motivating factors behind the antisocial behavior of a child, the chances are far greater that the reaction will be solitary, the individual boy or girl not confiding his or her activities to any one. Here the reaction appears to be so essentially hysterical or neurotic that, for all the culprit's misbehavior, one cannot possibly call it psychopathic. The child in question gets himself involved in a maze of conflicting emotions and, hysteric-like, becomes panicky, flops around like an animal caught in a net, and then takes the first available exit, regardless of what this may lead to. Where children band themselves together in "Al Capone" gangs, the situation is much more benign, for not infrequently it is a stage in normal development that leaves no traces behind. Where, however, it persists, one must search for the same types of factor as were at work in the first instance above mentioned—viz., neurotic constellations that involve the individual youth in a series of tension states from which criminality seems to be an escape.

Let us now take up puberty and adolescence, periods in which the young boy and girl become tremendously occupied with themselves. Youth exacts and demands all and is un-

willing to give anything in return. It is a dangerous age because so much has to be transformed in a relatively brief span of time. The problems that have been confronting the youth as a child become more insistent in their demand for expression, and criminal behavior at this age is only a result of a blind striving to solve these problems. Some children will come through unscathed, some may be precipitated into ephebic psychosis, some may be driven to suicide, and some escape by way of criminal behavior.

There is a persistent popular impression that the majority of criminals show their first tendencies toward crime during adolescence. But if there is some truth in what I have just said, then you will have to grant me that the adolescent period, for all the stress and strain that go with it, cannot entirely account for criminal behavior, which is merely an outward extension of developing factors that have been preparing themselves since infancy. Thus the periods following adolescence are related to adolescence in the same sense as adolescence is related to preceding periods. For in the subsequent stages of development—maturity, involution, and senescence—criminal behavior is just as apt to appear as in the earlier, although its particular forms of expression and perhaps the immediate psychogenetic factors vary. With wide exception forth and back, the mercenary type of criminal is more apt to begin in adolescence, the sexual offender in the early ages of maturity, the murderer from "passion" in the middle of maturity, and so on. That is to say, each stage or development may perhaps have its particular types of crime, just as each social class has its types of crime, though no stage or class is immune from antisocial behavior. So here again we find ourselves confronted with the situation that there is no age period which is entirely immune from criminality when it is also not immune from neurotic behavior.

The normal individual is able to relinquish his personal desires in the interests of society. Such sacrifice is extremely difficult for an unadjusted individual, and one might even say that the lack of adjustment of an individual to society is in almost direct proportion to his inability to renounce his personal strivings for larger social interests. The normal indi-

vidual is able to effect a constructive compromise, but many people experience a difficulty in doing that. This difficulty may take two forms of expression: The individual may succeed in the sense that society is protected from his antisocial strivings, but he pays the price in personal sufferings; this is the way of the neurotic. Or, unwilling to pay the price of personal suffering, he may make society suffer; that is, he is psychopathic. Sometimes in the effort to save society from the consequences of his social behavior, the individual indulges in a behavior that is much less extreme than that originally striven for, though society appears to suffer, as in the case of kleptomania, exhibitionism, and so on. It is at this point, we think, that neuroses and crime are confluent.

The home is the starting point of normal behavior, of neurotic behavior, and equally of criminal behavior. The making of a good citizen can be traced directly to his early years, and to his reaction to the affection given by the various members of the family. We are all born criminals in the sense that we are born without repressions. It is culture that conditions repression. Our purpose, therefore, is to find why repression has failed; why the individual has failed to learn the lesson of personal obedience in the service of culture.

The responsibility of the family is grave. It cannot be denied that criminals develop through failure on the part of the family to provide binding emotions, necessary to keep the child within the family. The next problem is to discover what prophylactic protective measures we can take in order to bring into play these binding emotions. If there begins to develop a disturbance in the balance between the child's loves, hates, and fears, then the child will be a neurotic or a criminal. A neurotic criminal is one who strives toward ends which, from the social point of view, are more or less worthless, even dangerous in themselves, and therefore unacceptable socially, particularly because the means adopted in attaining these ends are antisocial.

It has not been possible for me, within the limited time available, to elaborate on this problem, or to present the factual material necessary to support the conceptions I have outlined. The main point I wish to emphasize is that crime

is an emotionally conditioned reaction which, like other emotionally conditioned reactions, takes its origin in the early life of the individual; that there is no period in a person's life that may be said to be more characteristically criminal than any other period, but that in every period of life, from childhood until senescence, criminal behavior may be in the making and in the working.

COLLEGE MENTAL-HYGIENE METHODS *

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ABUNDANT literature is available to demonstrate the magnitude of the college mental-hygiene problem. Methods of approach to the problem, however, have been puzzling to all educators and student health departments. It is rare to find in a college or university any well integrated scheme for the detection and management of personality difficulties among the student body. Obviously a simple, workable plan is necessary to meet the needs of the great number of unstable students in our colleges and universities. The general plan proposed by us in a previous contribution,[1] which has been in force over a period of four years at the University of Pennsylvania and which has proved serviceable in other schools, does not meet all of the requirements because it has not reached directly the student in need of immediate help. The present contribution aims to present the plan under which we had been operating and to assay its positive and negative features. We also intend to present as concretely as possible an enlarged plan. It is our hope to make available for general use the readily applicable scheme that we are finding valuable and to discuss some of the broader problems encountered by mental-hygiene workers in the field of education.

Our first aim has been to reach the faculty of the university in an effort to create a mental-hygiene consciousness. The psychiatrist in the health service is responsible for the dissemination of mental-hygiene concepts among the faculty

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[1] *Mental-Hygiene Problems in a University*, by Harold D. Palmer, M.D. MENTAL HYGIENE, Vol. 18, pp. 233–44, April, 1934.

members. Richmond[1] states that one of the chief functions of the psychiatrist attached to the university health service is this of educating the faculty. She feels that the resistance of the faculty is usually quite material, representing "the greatest hindrance to a successful mental-hygiene program in most colleges." We have distributed to members of the faculty reprints of good articles in current journals on the collegiate aspects of mental health. Certainly it is true that instructors occupy the most advantageous position for observing, and are often the first to observe, the early symptoms of emotional stress. It is within their power to do much to prevent the development of more malignant nervous or mental disease.

The second line of defense consists of a well-chosen personnel officer and the freshman adviser in each college. Students in whom the faculty recognize difficulties are referred promptly to the personnel officer for more highly individual guidance. In our experience, the ordinary problems that arise from poor work, wrong methods of study, irregular hours, disciplinary difficulties, the outside job and its encroachment on the mental and nervous stability of the student, are all dealt with to a large degree by the personnel department. Those cases in which it is felt that a more fundamental psychological investigation is needed are referred to the psychiatrist. Conferences take place between the personnel officer and the psychiatrist, and almost invariably the recommendations made by the psychiatrist are put into effect. Frequent contacts with the deans, vice-deans, and personnel officers of the various schools keep alive a genuine mental-hygiene interest, and the fruits of these conferences have been most worth while.

One of the most important parts of any college mental-hygiene program is the vocational-psychological department. Although this is a separate clinic at the University of Pennsylvania, the help received through referring students for complete vocational-psychological study has been most satisfactory and encouraging. Unfortunately, such a division is to be found only in the larger universities and in mental-hygiene institutions. It has been our experience that a change

[1] See "Mental Hygiene in the College," by Winifred Richmond. *Journal of the American Medical Association*, Vol. 93, pp. 1936–39, December 21, 1929.

of schools or a redirection of professional training into the field most suited to the individual's potentialities has often been sufficient to turn the student's course from mental chaos to mental order. The lack of a definite educational goal is one of the most potent sources of mental conflict and emotional distress. One can scarcely overemphasize the sense of insecurity that assails the average college senior who has gone to an institution of higher learning solely for a degree, or because in his social group it was the thing to do, or because it would be a tragic blow to his family if he did not follow out the profession chosen for him by his parents. Fitting round pegs into round holes is the work of the psychological clinic. It is advisable for all cases referred for vocational-psychological guidance to go first through the hands of the psychiatrist.

One of the chief sources of help for students who present psychiatric problems is the group of physicians attached to the staff of the student health service. This is logical, since acute emotional distress is almost always reflected in physical symptoms. The conversion of mental conflict into somatic symptoms is one of the fundamental phenomena which a well-trained medical man could not fail to recognize. Not all students with psychic disturbances who appeal to the medical, surgical, or other departments of the student health service need to be referred to the psychiatrist. Many cases of anxiety over physical symptoms can be and have been satisfactorily dealt with by other members of the medical staff. As long as the medical personnel is mental-hygiene conscious, the proper cases will be referred to the psychiatric department.

Our efforts have also been directed at the problem of reaching the student as directly as possible. Patry[1] feels that mental-hygiene courses given to the students have value in bringing to the psychiatrist many problems that might not otherwise come to light. The program, he believes, ought to include lectures to faculty members also. Emery[2] elaborates

[1] See *Some Suggestions on Mental-Hygiene Programs for Schools and Colleges*, by F. L. Patry, M.D. MENTAL HYGIENE, Vol. 18, pp. 621–28, October, 1934.

[2] See *The Content and Method of Instructing College Students in Mental Hygiene*, by E. Van Norman Emery, M.D. MENTAL HYGIENE, Vol. 17, pp. 590–97, October, 1933.

the content and method of instruction in mental hygiene for college students. He proposes courses presenting a critical orientation (a) with respect to the social and psychological nature of man and the dynamics of human behavior and human interrelationships, and (b) with respect to those social problems that arise on the basis of mental and emotional disturbances and the instruments with which society has attempted to meet them. More specifically, he urges prescribed reading of books and articles related to personal mental hygiene, lecture courses, group participation or seminars and individual instruction (psychotherapy). Mental-hygiene content, he states, should be "related with meaning to the social and emotional problems that confront the student, and the method should recognize the importance of the dynamic factors in the instructor-student relationship. There should be a keen appreciation that education consists in the self-determined development of the student, rather than in chiseling him into a grotesque caricature of the instructor's self-beloved image."

At the Wharton School, the largest of the colleges of the University of Pennsylvania, four lectures are given by the psychiatrist each year as part of a "general-orientation course." The material presented covers a general discussion of mental-hygiene needs and statistical data regarding the magnitude of the problem of mental health. Parallels are drawn, showing the logic of an individual mental-hygiene program in addition to the generally recognized physical-hygiene program. There is also a discussion of personal mental hygiene, and the concepts of a well-balanced life are elucidated at some length. The lectures are concluded by a brief description of the functions of the college mental-hygiene department, and the students are left with a knowledge that there is a service founded primarily to assist those who find themselves aimless, nervous, unfitted for the profession they seek to pursue, or floundering about and in danger of being submerged by personality problems.

A course of lectures has been given as an elective in the department of physical education. This consists of 33 hours of lectures covering the field of psychiatry, with special emphasis on the early recognition of personality deviations in adolescent children. The response to this elective course

has been most encouraging. It is our belief that here lies one of the greatest opportunities in the entire field of mental hygiene—to point the way to help in the early case of personal maladjustment. Graduates of the department of physical education in our large universities become the coaches, physical instructors, and class advisers in the schools and colleges of the country. Other schools in the university also are considering the introduction into the curriculum of a course in mental hygiene.

In spite of the fact that up to the present such an organization of mental-hygiene effort has been quite satisfactory and productive, in a limited way, of highly gratifying results, yet it has a weakness in that it fails to reach at the earliest possible moment the student who needs help. Other workers have recognized the importance of this and have suggested various ways of doing it.

Frankwood Williams, in discussing a paper presented in 1929 by Winifred Richmond,[1] proposed a modified army technique for making contact with the unstable student. He suggested that the psychiatrist be in the line-up of examining physicians at the time of the students' entrance examinations and be given an opportunity for a few minutes' conversation with each student. Those who show need for psychiatric help are thus "spotted" and asked to return for further interviews. Williams believed this method to be highly successful.

Cobb at Harvard made a brief neuropsychiatric examination of 1,141 students at the time of entrance to college.[2] He found that 16.4 per cent gave a neurotic history in response to queries covering personal history, family history, and present complaints. Cobb felt that fifteen minutes were insufficient for even a cursory examination and concluded that the history is the best guide to nervous instability. Eight physicians were employed to carry out these tests. The magnitude of such a study, valuable as it is, precludes its application where experienced personnel is limited.

Muenzinger published the results of a student questionnaire covering "nervous conditions" (nervous breakdowns,

[1] See note 1, page 398.

[2] See "A Report on the Brief Neuropsychiatric Examination of 1,141 Students," by Stanley Cobb, M.D. *Journal of Industrial Hygiene*, Vol. 3, pp. 309–15, February, 1922.

chorea, hysterical attitudes, night terrors, etc.), "undesirable traits" (instability, inability to concentrate, self-consciousness, etc.), and "causes of worry" (physical health, friends, scholastic standing, economic state, home, etc.).[1] She attempted to get at the emotional status directly by this method, referring those students who showed unfavorable signs to the personnel officers, the student health department, and other proper sources of guidance and advice.

Several years ago Peck[2] pointed out the advantages of a routine mental examination of college students. He felt such an examination would be of definite help to the student. Some of his cases were taken at random; the others were referred.

In a recent critical review of our mental-hygiene organization, many cases referred to or coming to the psychiatrist directly over a period of four years were carefully examined to determine how some of the unfortunate developments could have been prevented. A study of the student-health questionnaires made out at the time these students entered the university showed that replies indicative of definite instability were found more than ten times as frequently in them as in the questionnaires of a similar number of students coming to other branches of the health service. It became obvious to us that the routine student-health questionnaire made out by every new student entering the university could serve as a valuable source of psychiatric history and symptomatology which would enable us to detect unwholesome trends at that time.

At the University of Pennsylvania every freshman or new student except those in the law, dental, and graduate schools, as a routine phase of his entrance into the university, fills out a detailed questionnaire, called the "Physical Examination Form of the Student Health Service." The present examination forms in use in the Student Health Service of the University of Pennsylvania are a composite prepared by student health experts, Drs. H. S. Diehl and H. D. Lees, who took as a basis the periodic health-examination forms prepared by the

[1] See "Physical and Mental Handicaps in Girls Entering the University of Colorado," by Florence W. Muenzinger, M.D. *Colorado Medical Journal*, Vol. 27, pp. 8–13, January, 1930.

[2] See *Mental Examination of College Men*, by Martin W. Peck, M.D. MENTAL HYGIENE, Vol. 9, pp. 282–99, April, 1925.

American Medical Association. Modifications and additions were made from a large experience with college health matters. Emphasis throughout is put upon the problems and disorders especially characteristic of the college student. A similar form seems now to be in rather wide use in the larger colleges and universities. Its applicability and usefulness for smaller colleges is obvious. The varied questions are designed to bring out a remarkably thorough psychiatric history. From a study of the questionnaire alone, a practical and fairly comprehensive view of the student's personality and emotional integrity can be obtained. As will be seen, from examination of the portion of the form published here (pages 404–407), the data secured include a serviceable family history, the past medical history, the circumstances under which the student lives, how he uses his spare time, the regularity and correctness of his dietary and sleep habits, and a review of his history by systems. Especially on page 407 (page 4 of the questionnaire) is a brief, but valuable psychiatric history. Six direct questions under Code B elicit any abnormal traits that might offer valuable clues to the psychiatrist who reviews the data.

With the exception of Code B, the examination form is so arranged that the student is not at all conscious of giving a personal psychiatric history, and consequently is not on guard against "a lot of psychological stuff." In actual practice, the replies to the questionnaire have been remarkably accurate.

Each questionnaire is submitted to a member of the psychiatric department for evaluation. One to two minutes is ample time in which to review it. Questionnaires that contain data considered by us significant from a mental-hygiene standpoint are marked in accordance with the severity of the problem presented. Students whom we believe to require immediate care are seen within the next few days after the questionnaire is examined. Those presenting relatively severe, but not acute, neurotic symptoms are marked with two stars, and regular notices are sent to them to report to the health service for further check-up on their general conditions. No mention is made of the psychiatric significance of their questionnaires. Those students whose questionnaires give general clues as to a moderate degree of nervous instability are marked with one star and are taken up for routine

PHYSICAL EXAMINATION

No. _____ (Col. 1-5)

STUDENTS' HEALTH SERVICE
University of Pennsylvania

FORM FOR MEN Date _____ (Col. 6. Code last digit)

(Important.—Fill in this page at the time of your first examination. Use a ✓ mark for affirmative, O mark for negative replies, and a ? mark if you do not know. Do not leave any question unanswered.)

Name _____ College _____ (Col. 7-8. Code 1) Year { Freshman, Sophomore, Junior, Senior, Graduate, Unclassed } { Single (1), Married (2), Widowed (3), Divorced (4) } (Code direct) (Col. 9)

Dates of previous physical examinations at University of Pennsylvania _____

Address:—City _____ Age (nearest birthday) _____ (Col. 10, 11. Code direct)

Home _____ Religion _____

Country of your birth _____
" " father's birth _____
" " mother's birth _____
(Col. 12-13) (Code 3)

Population of community in which you spent most of your life before coming to college { Less than 50 (a), 50–999 (b), 1000–4999 (c), 5000–49,999 (d), 50,000 or more (e) }

CODE A

Family History:

Father living (f) Age _____
Dead (g) Age at death _____
Cause of Death _____
During most of your childhood were you the { only child (a), eldest child (b), youngest child (c), neither eldest nor youngest child (d) } at home (Col. 15)

Mother living (f) Age _____
Dead (g) Age at death _____
Cause of death _____ (Col. 14)
How many brothers have you living _____
sisters living _____
How many brothers dead _____
sisters dead _____

In the following figure put a ✓ mark in the proper space to indicate illness, past or present, among your relatives:

		(Code B)	Paternal: Father	Grandfather	Grandmother	Uncles	Aunts	Maternal: Mother	Grandfather	Grandmother	Uncles	Aunts	Brothers	Sisters
Tuberculosis or consumption	(1)													
Apoplexy or stroke	(2)													
Kidney trouble or Bright's Disease	(3)	(Col. 16)												
High blood pressure	(1)													
Heart disease	(2)													
Sick headaches	(3)	(Col. 17)												
Convulsions or epilepsy	(1)													
Nervous trouble	(2)													
Mental trouble	(3)	(Col. 18)												
Cancer	(1)													
Diabetes	(2)													
Tendency to bleed easily	(3)	(Col. 19)												

CODE B

Check the following past illness which you have had, after the check mark write the age at which you had the illness, put a O after the ones you have not had.

Scarlet fever	(1)	Measles	(1)	Syphilis	(1)
Diphtheria	(2)	Smallpox	(2)	Gonorrhea	(2)
Inflammatory rheumatism (Col. 20)	(3)	Pneumonia (Col. 22)	(3)	Whooping cough (Col. 24)	(3)
St. Vitus dance	(1)	Influenza	(1)	Malaria	
Nervous breakdown	(2)	Tuberculosis	(2)	Chickenpox	
Typhoid fever (Col. 21)	(3)	Pleurisy (Col. 23)	(3)	Heart Disease Others	

Have you ever had any { broken bones, operations on nose or throat, other operations }

3

Use ✓ marks for affirmative and O for negative replies whenever possible. Do not leave any unanswered.

Living conditions while attending University:—
At home (a)
In family other than your own (b)
In rooming or fraternity house (c)
In dormitory (d)
Congenial and quiet
(Col. 25. Code A)

Congenial and noisy
Depressing
Irritating
Conducive to study
Not conducive to study

Are your funds adequate to support yourself comfortably Yes (f) No (g)

CODE A
1—a+f
2—a+g
3—b+f
4—b+g
5—c+f
6—c+g
7—d+f
8—d+g

Are you { partially self-supporting (a) / completely self-supporting (b) / not self-supporting (c) }

Are you working toward your support during the school year { Yes (f) / No (g) }
(Col. 26)

How did you spend last summer { On vacation (a) / In school (b) / Working full time (c) / Working part time (d) }

Were you in school anywhere last year { Yes (f) / No (g) }
(Col. 27)

If working last summer, what was the nature of your work { Physical work, housework, or odd jobs (a) / Salesman or agent (outdoors) (b) / Clerical, office, or technical indoor work (c) / Not working (d) } (Col. 28) (Code A)

Is any one else dependent even in part, upon your earnings. Yes (f) No (g)

If working during the school year, how many hours per week does your employment require { Less than 15 (a) / 15 to 39 (b) / 40 or more (c) } (Col. 29)

And what is the nature of your work { Physical work, housework, or odd jobs (x) / Salesman or agent (outdoors) (y) / Clerical, office, or technical indoor work (z) } (Code C)

CODE C
1—a+x
2—a+y
3—a+z
4—b+x
5—b+y
6—b+z
7—c+x
8—c+y
9—c+z

What extra-curricular activities, other than athletics, are you engaged in _____

How many hours per week do these require _____

What exercise do you take in addition to your work, and what sports do you engage in _____

_____ Hours per week _____

How much tobacco do you use per day _____ How frequently do you use candy _____

In what social organizations (fraternity, club, church, etc.) do you take an active part _____

What are your pleasures and recreations _____

This column to be checked by physician

Extra-curricular activities:—
None (a)
Moderate (b)
Excessive (c)
Sports and athletics:—
None (x)
Moderate (y)
Excessive (z)
(Col. 30. Code C)

Tobacco:—
None (a)
Moderate (b)
Excessive (c)
Recreation and social activities:—
None (x)
Moderate (y)
Excessive (z)
(Col. 31. Code C)

How many meals do you eat daily _____ Time of meals _____

Regularly _____ Where _____ Between meals _____ Before retiring _____

Are you a { small / moderate / hearty } eater

How much do you drink daily of { milk _____ glasses / water _____ " / tea _____ cups / coffee _____ " / soft drinks _____ glasses }

List the foods of which your average meal consists:—
Breakfast _____
Lunch _____
Dinner _____

Do you have a room to yourself Yes No

CODE D
1—a+f+x
2—a+f+y
3—a+f+z
4—a+g+x
5—a+g+y
6—a+g+z
7—b+f+x
8—b+f+y
9—b+f+z

Diet adequate (a)
" inadequate (b)
Eating habits:—
Good (x)
Bad (z)
Room
Yes (x)
No (y)
(Col. 32. Code D)

What is the average number of hours you sleep at night _____

What is your usual retiring hour _____ Rising hour _____

Is your sleep regular _____ restful _____ disturbed _____

Do you have a bed to yourself _____ Keep windows open at night _____

Do you stammer or stutter Yes (x) No (y)

Sleep adequate (a)
" inadequate (b)
Sleeping habits
good (x)
bad (z)
(Col. 33. Code D)

3

Place a √ mark after those conditions to which you are subject and a O after those which you never have.

Earaches
Discharge from ears
Deafness
Ringing in ears

Aching eyes
Eyes sensitive to light
Inflamed lids
Styes
Blurred vision
Double vision

Sinus infection
Chronic discharge from nose
Frequent colds in the head
Difficulty in breathing thru nose
Nosebleed
Hay fever

Frequent sore throat or tonsilitis

Colds with persistent cough
Bronchitis
Hoarseness
Cough without recent cold
Pain on breathing
Spitting blood
Night sweats
Asthma

Over the past two years: have you gained in weight_____How much_____Lost weight_____
How much_____Maintained the same weight_____

Sensation of heart beating
" " " " unusually slowly
" " " " " rapidly
" " " " irregularly

Shortness of breath upon moderate exertion
Choking sensations
Pain over chest
Tight feeling over chest
Swelling of hands, feet, eyelids
Muscle cramps
Did you have growing pains in childhood
Rheumatism of any kind

Is your appetite below normal—average—excessive
Is your thirst below normal—average—excessive
Are you subject to abdominal discomfort (indigestion)
Is it unrelated to meals
after meals
when stomach is empty
accompanied by constipation
accompanied by diarrhea
Are you subject to belching of gas
Do you have a bowel movement daily
How frequently do you take cathartics_____
What kind_____
Do you have pain with bowel movements

Burning or smarting urination
Too frequent urination during day
Necessity of urination during night

This space for amplification of positive symptoms by physician.

6

Place a √ mark after those conditions to which you are subject and a O after those which you never have.	This space for amplification of positive symptoms by physician.
Nervousness	
Insomnia (sleeplessness)	
Sense of exhaustion	
Headaches, unrelated to colds	
Fainting spells	
Fits or convulsions	
Dizziness	
Backache	
Tingling in hands or feet	
Stammering or other speech difficulty	
Have you ever been refused life insurance. Yes. No.	
Do you consider yourself in good health If not, what is your complaint	
Do you wish to discuss any question in regard to your health, family history, sex, or personal habits with a physician. Yes No	(Omit Col. 34)

CODE B

1=1
2=2
3=3
4=1+2
5=1+3
6=2+3
7=1+2+3

Put √ after affirmative replies, O for negative.

Are you subject to worries (1)

Are you particularly self-conscious (2)

Are you bothered by a feeling that people are watching you or talking about you (3)
(Col. 35. Code B)

Are you subject to moods (1)

Are you subject to periods of alternating gloom and cheerfulness (2)

Are you inclined to be secretive and reclusive (3)
(Col. 36. Code B)

CODE

1—No vac., Susc. Diph.
2—Unsusc. vac., Susc. Diph.
3—Old vac., Susc. Diph.
4—Rec. vac., Susc. Diph.
5—No vac., Imm. Diph.
6—Unsusc. vac., Imm. Diph.
7—Old vac., Imm. Diph.
8—Rec. vac., Imm. Diph.
(Col. 37)

Have you been vaccinated against smallpox_____ Date of first successful vac._____

Did it leave a scar_____ Date of last successful vac._____

Did you ever have smallpox_____

Have you ever had a Schick test_____ Result of last one_____ Date_____

Have you ever had toxin-antitoxin inoculations against diphtheria_____

Have you had inoculations or antitoxins against other diseases_____ What_____

(DO NOT FILL IN BELOW THIS LINE)

ADDITIONAL DATA FOR WOMEN STUDENTS

Menstrual History: Age Menstruation was begun_____

Amount: small_____ medium_____ profuse_____

Regular every_____ days. Duration_____ days.

Irregular every_____ days. Discomfort_____ days.

Pain_____ days. Character of pain: cramps_____ dull_____

backache_____ Go to bed: every month_____

at least every other month_____ occasionally_____

Miss classes every month_____ occasionally_____

Previous treatment for menstrual disorders

Age Menstruation Began

10 years or under
11 years
12 years
13 years
14 years
15 years
16 years
17 years
18 years
19 years or over

(Col. 60)
Code last number

Menstruation

Normal
Irregular
Menorrhagia
Amenorrhea
No previous treatment
Previous medical treatment
Previous surgical treatment
(Col. 61)

Dysmenorrhea

Bad every month
Bad every other month
Bad occasionally
Miss classes every month
Miss classes occasionally
Do not miss classes
(Col. 62 Code C)

CODE

1=a+f
2=a+g
3=b+f
4=b+g
5=c+f
6=c+g
7=d+f
8=d+g
9=b+c+f
10=b+c+g

CODE C

1=a+g
2=a+y
3=a+x
4=b+x
5=b+y
6=b+z
7=c+x
8=c+y
9=c+z

Omit Col. 34

interviews after all of the more urgent cases have been seen. An hour is allowed for these interviews.

Many students receiving the notice are somewhat concerned and a little fearful about the possibility of some serious physical defect. This is especially true of those who have been told at some time that they have a "murmur" or "heart trouble." At the beginning of the interview the student is put at his ease by the friendly attitude adopted by the psychiatrist. Everything possible is done to eliminate the feeling that he is being "examined by the psychiatrist." The student is told that the notice he received is part of the routine program of looking after the students' welfare and that it is not thought he has anything seriously wrong. He is informed that the examiner merely wants to do his part in eliminating all possible hazards from the student's college life. He is made to feel that the health service is really interested in him. The physical symptoms are taken up first and special emphasis is placed on those involving insomnia, fainting spells, nervousness, speech difficulties, phobias, nervous breakdowns, paræsthesias, or other possible psychogenic symptoms. The student is encouraged to talk freely about his future plans, and the interview goes on more as a friendly inquiry into the student's general plan of life than a specific investigation into any nervous or psychological disorders. If during the course of the discussion the psychiatrist is led to believe that the student is suffering from a major emotional disorder, the interview is gradually directed toward that problem and the student is encouraged to return if he wishes further help. Careful records of these interviews are kept by the mental-hygiene division of the health service. The following three cases will illustrate some of the problems which our present plan, put into effect this year, is designed to forestall.

Case 1.—A boy, aged eighteen, entered college September, 1934; dropped out in February, 1935; committed suicide March, 1936. This student never applied for aid to the health service or sought advice from teachers; therefore, no personal problem was known to exist.

Review of the data in the physical-examination form, filled out by the student at the time he entered the university, and available for psychiatric evaluation eighteen months before the tragedy, revealed the following relevant facts: The boy was the youngest of five children of foreign-born Russian-Jewish parents. He lived at home several miles from the college and was partially self-supporting, working

several hours each school day and on week-ends. He did not belong to any social organizations, church groups, clubs, or fraternity. His interests centered only about reading, music, and drama. He suffered from "eye-ache" when he did not wear glasses, and his eyes were hypersensitive to light. He suffered from nervousness and had a desire to discuss personal or sex problem with a physician. He was subject to worries, was very self-conscious, and was bothered by a feeling that people were watching him and talking about him. He was subject to moods and periods of alternating gloom and cheerfulness and was inclined to be secretive and seclusive. The physical examination at entrance showed him to be physically inadequate, small, thin, with marked scoliosis, winged scapulæ, and compensatory angulation of the ribs. There was acne of the face, and a septic tonsillar tag, and there were four unerupted teeth. The student never returned for recheck of a low-grade fever, though he was asked to.

It seems obvious that any psychiatrist, given the opportunity to review such data, would have insisted on subsequent visits and have obtained further data to complete the story of the serious maladjustment. At once psychotherapy could have been made available and the tragedy might have been averted.

Case 2.—This boy of twenty entered the college in September, 1934. In February, 1936, he went to his vice-dean and expressed a wish to resign because of personal inadequacy and failure in college. His scholastic standing was fair and his instructors had reported him to be a careful, conscientious worker, a little slow and sometimes preoccupied and anxious, but not inadequate. The vice-dean referred him to the college psychiatrist at once.

At the time of his visit to the psychiatrist in February, 1936, a review of the data contained in the physical-examination form, filled out one-and-a-half years earlier, revealed the following facts: The student was the eldest child of three. There were diabetes and cancer in the ancestry. He lived in a dormitory, which he found congenial, but noisy and not conducive to study. His interests were football and journalism, movies, reading, and card games. He suffered from blurred vision, nasal obstruction, frequent tonsillitis and laryngitis, and chronic constipation. At times he had insomnia because of worry, and occasionally an attack of vertigo. *He asked to consult a physician about personal sex problem.* He was self-conscious, subject to worries, at times had moods and was aware of alternating gloom and cheerfulness. He believed himself to be abnormally seclusive and found it difficult to make friends. Physical examination revealed asthenic physique, systolic murmur, slight impairment of hearing in the right ear, and a "potential" right inguinal hernia.

In several periods of frank discussion with the psychiatrist, it was learned that he had struggled unsuccessfully with masturbation, that he had worried excessively about the problem and had begun to develop anxiety. Neurotic symptoms had been in evidence for a period of a year and finally, in the middle of his second year, he felt that he could no longer stand the burden of his worries and guilt feelings and continue to do college work and decided to leave school and seek hard

manual work. He had in some way obtained a number of useless books on the subject of sex and had been informed by them, and unfortunately by his family physician, that "masturbation led to insanity or feeble-mindedness." The mental inefficiency occasioned by his conflicts convinced him that mental disease had overtaken him and that there could be no escape from the fate which he had brought upon himself. The rapidly developing psychopathological process need scarcely be pointed out. The student's course was obviously pointing downward when he was referred to the psychiatrist. We were interested in the possibility of a mild manic-depressive reaction, but this was ruled out.

Eight therapeutic hours have now been spent with this student. He has finished his second year to his own satisfaction and to that of the faculty. His problems now seem to him to be relatively simple, and he is dealing with them successfully. The outlook is satisfactory. Had the data contained in the replies of the questionnaire been available for evaluation by a psychiatrist, the seeds of a severe personality problem could have been readily detected at the time of his entrance into the university. The student might, if help had been made available, have been spared a year and a half of conflict and anxiety. His mind would have been freed for application to academic work and wholesome recreational pursuits.

Case 3.—A girl of twenty-four, a graduate student in education, was referred to the psychiatrist in January, 1936, because of complete scholastic failure and bizarre behavior toward one of her instructors. She had been an honor undergraduate student, had won Phi Beta Kappa, and was considered "brilliant."

A review of this student's entrance physical-examination form, dated September, 1931, gave the following interesting data: She was of Irish-American ancestry, the only child of now aged parents. She lived at home in the city, forty minutes' trolley ride from the university. Her mother was nervous, and an uncle suffered from some mental disease. She had had scarlet fever, pneumonia, and the usual contagious diseases of childhood. Her home environment was quiet and conducive to study. She had spent her summers at home studying music. She had no extra-curricular activities except that she sang in a choir and took piano lessons. She took no interest in sports and was not required to assist in the household routine. She had no contacts with social organizations. She slept from eight to ten hours every night. She suffered from nervousness, sense of exhaustion, and backaches, and considered herself to be generally in poor health. She wished to discuss a personal problem with a physician. She was particularly self-conscious and seclusive, and felt that people were unfriendly and watched and talked about her. She suffered from moodiness. Her menses had begun at seventeen and were regular, but scanty and accompanied by discomfort. She stated that her eyes were sensitive to light and that she suffered from palpitation and tremors.

Physical examination revealed poor posture, asthenic habitus, moderate hypotension, 20 per cent underweight, sweaty, cold hands and feet, enlarged tonsils, tendency to flat feet.

On psychiatric examination the patient was found to be a typical schizophrenic of the hebephrenic type. She stated that she had received "messages" from a Mr. H. which virtually amounted to a proposal of marriage. She had written him numerous fragmentary notes and a poem or two. She had a theory about imparting knowledge to pupils "without the use of speech, print, or pictures." She felt that she had been chosen to do this special work, and that Mr. H. was to be her co-worker. She was excited, discoursed in a rambling fashion, and displayed silly mannerisms. Further history elicited from the patient and her family showed that she had spent the summer of 1934 in isolation, writing up a "code" which was to apply to her academic future. She had made up a motto, expressing her academic ideal, which was painted in bold letters on each side of her notebooks, "A Plus or Nothing." She had never spent a night away from home, knew nothing of the city except the route to and from the university, had never been out with a boy, nor attended a party or dance.

A psychiatric evaluation of this girl's entrance-examination form, four and a half years before the development of a frank psychosis, could have detected in her a grave degree of introversion and potential instability. Constructive psychotherapy begun at that time might have swerved her course away from further isolation and prevented the unhappy culmination.

In our university it is quite unusual to have the shy, asocial, schizoid types referred to the psychiatrist. This comes about, perhaps, because the introvert is usually a good student, presents no problem of discipline, is passive and not likely to be obvious in the classroom. The mild hypomanic or the highly neurotic student is usually referred promptly, the former because of his expansive and irritating behavior, and the latter because of his tendency to emphasize to his instructors the handicaps under which he struggles to keep up his scholastic standing. The questionnaire has proved of great benefit in the detection of the early schizoid type. Their response to therapy begun early in the college career is encouraging.

Evaluation of the questionnaire by a psychiatrist seems to us, therefore, to present a very practical technique for the detection of unstable trends at the very moment the student is launched upon his college experience. In the majority of cases the completed questionnaires from those students who have come to us check closely with the more detailed accounts we are able to obtain later in personal interviews.

Such an approach, however, requires a personnel larger than we have had available in the past. Recently, through a grant of funds, we have been able to enlarge the psychiatric staff, to study the situation more closely, and to take adequate time to formulate a plan aimed at the earliest possible detection and therapeutic management of personality disturbances. It is significant to note that one full-time psychiatrist, one part-time psychiatrist, and one secretary have been able to review more than 220 cases during the first semester and at the same time have continued to carry on therapeutic interviews with students who require treatment.

All of those students who were thought by us to be in need of at least one introductory interview were seen at least once by the psychiatrist before the end of the first semester.

The questionnaires of 1,619 new students registering in the university were carefully evaluated. This number represents all new students except those matriculating in the law, dental, and graduate schools, whose students are not required to fill out the questionnaire or submit to physical examination. Sixty-four and nine-tenths per cent of the questionnaires (1,050) contained data indicating some degree of emotional maladjustment. Of this number 265, or 16.4 per cent,[1] were thought by us to indicate such severe emotional maladjustments or definite personality defects as to need immediate psychiatric help. Certainly it appeared important to bring about a psychiatric interview at the earliest possible moment in order to determine the nature of the emotional stresses from which the student was suffering. We believe it is very significant that so high a percentage of new students indicated in questionnaires alone such evidence of emotional disturbance that a psychiatric follow-up seemed imperative. This group (the students double-starred in the original survey) made up 25.2 per cent of the 1,050 who seemed to need psychiatric help. Seventy-nine per cent of these students who received notices from our department to report at the health service for further check-up responded promptly. The majority of the others came in after a second notice was sent to them. To date (first semester 1936–37) 224 of the students thought by us to be in need of psychiatric help have been interviewed for at least one hour and 14 have continued to seek

[1] It is interesting that this figure checks exactly with that given by Cobb, *loc. cit.*

psychiatric help voluntarily. The problems presented varied widely in nature. The full scope of the problems dealt with will be presented in a subsequent communication. In the broadest terms, many expressed desire for help in the perplexing personal problems that assail many freshmen in university life, while others felt quite definitely in danger of being submerged by severe psychoneurotic reactions.

Two students whom we had called in for follow-up interviews were forced to withdraw from school because of the magnitude of their problems. In such cases the dean of the school in which the student is entered is notified at once, any conferences thought necessary are held, and the advantages to the student of withdrawal from school are discussed both from the mental-hygiene and from the academic points of view. It is felt that a great deal of valuable time has been saved by the prompt recognition of these more serious mental disturbances. Two students were sent to us by members of the faculty as emergency problems and were subsequently withdrawn from school. It is interesting to note that in each instance these students would have been sent for by the mental-hygiene department because of highly significant material in their questionnaires.

Three hundred and thirty-four questionnaires—20.6 per cent of those evaluated—showed evidences of minor disorders. During the second semester all of these students will be interviewed in the department of mental hygiene. Two students whose questionnaires were placed in this category developed nervous disorders of significant magnitude. The clinical picture presented by each at the time of withdrawal from school indicated that a long-standing schizophrenic process existed, so that at the time the entrance questionnaire was made out, the student was already incapable of giving a fair evaluation of his physical or emotional make-up. It should also be noted that 451, or 27.9 per cent, of all the new students checked such superficial nervous reactions as *worries*, stating, "Everybody has worries at times," or *nervousness*, stating, "All of us get nervous before examinations."

The overwhelming majority of students accept the psychiatric interview very graciously. They are not only fully cooperative, but express gratitude and appreciation for the interest taken in them. Only two of the entire number have failed to appreciate the helpful interest that has been taken

in them. It is very gratifying to find that the students who we believe need help most seriously welcome the opportunity to begin a therapeutic procedure. We have also found that a single interview is not infrequently sufficient to eradicate fears and perplexities that have potential danger. In general, whether the student is asked to return for subsequent interviews or not, the response has been most satisfactory and such statements as, "Doctor, I certainly want to thank you for your time, and I want you to know that I appreciate this," are common.

The following summary gives the results of our investigation to date:

1. Total number of student questionnaires evaluated:
   - Men. 1,137
   - Women. 482
   - Total. 1,619
   - Ratio of men to women, 2.4 : 1
2. Number of questionnaires that were of significance, no matter how slightly:
   - Men. 757
   - Women. 293
   - Total. . . . . 1,050, or 64.9 per cent of total
   - Ratio of men to women, 2.6 : 1
3. Number of questionnaires that indicated need for prompt psychiatric help:
   - Men. 202
   - Women. 63
   - Total. . . . . 265, or 16.4 per cent of total; 25.2 per cent of significant questionnaires.
   - Ratio of men to women, 3.2 : 1
4. Number of students who responded to notices promptly:
   - Men. 158
   - Women. 51
   - Total. . . . . 209, or 78.9 per cent of significant questionnaires.
   - Ratio of men to women, 3.1 : 1
5. Number of one-starred questionnaires indicating minor emotional problems:
   - Men. 246
   - Women. 88
   - Total. . . . . 334, or 20.6 per cent of total; 31.8 per cent of significant questionnaires.
   - Ratio of men to women, 2.8 : 1

6. Number of questionnaires not starred, but possibly significant:

Men.	309
Women.	142
Total.	451, or 27.9 per cent of total; 43.0 per cent of significant questionnaires.

Ratio of men to women, 2.2: 1

SUMMARY

The problem of early detection and management of emotional disorders among students in our university has been met over a period of four years by the plan that we have just described.

In all colleges and universities it is obviously essential to create a high degree of mental-hygiene consciousness among members of the faculty, since they have the first opportunity to recognize evidences of emotional maladjustment in the student. Because of the minor difficulties arising from poor study habits, irregular hours, and the like, the personnel officer is another important feature of any well-integrated mental-hygiene plan. The lack of a real occupational goal in the lives of many of the students makes the vocational-psychological clinic a very valuable ally. The other physicians (medical, surgical, etc.) in the student health service constitute a vital part of the program because of the frequency with which somatic complaints are associated with, and often lead to the prompt detection of emotional difficulties. Cases not readily dealt with by reassurance and suggestion are referred to the psychiatrist. Lectures to the student body and courses in mental hygiene in the various schools are offered as a more direct contact. In the study of student problems during the past four years, a constant effort has been made to check back to the earliest discoverable evidences of emotional instability. It became evident that the student health questionnaire required at entrance furnished some insight into the student's personality and that careful evaluation of the brief, but adequate, psychiatric data contained in it gave practical leads to the recognition of unwholesome trends long before the student had begun to manifest overt neurotic behavior. When indicated, the student can be interviewed promptly and offered opportunities for psychotherapy. Through such a scheme, readily applicable in all colleges and universities, it seems to us possible to avoid many serious difficulties in the subsequent college years.

MENTAL HYGIENE IN LEGAL-AID WORK

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ON the periphery of the field of social work, various legal-aid organizations make their contribution to the totality that we call "the well-being of society." The function of a front-desk attorney in such an organization is to interview the bulk of new clients, to counsel with them, and to develop their cases up to the point of actual litigation when necessary. The work is carried on by means of interviews and correspondence; no field work is attempted.

The concepts of social psychiatry come into play in this work to an extent little appreciated by the casual outsider. It is estimated by some of the workers in the legal-aid field that close to 10 per cent of their clients suffer from marked emotional maladjustments, ranging from the psychoses to milder personality disturbances. The reason for this high frequency is not far to seek. In the first place, individuals with fancied grievances commonly resolve them into an infringement of their legal rights. These individuals flock to legal-aid societies in great numbers, being directed thence by court attendants, police officers, and social workers, who are either desirous of ridding themselves of such persons or ignorant of the lack of any legal foundation for the applicant's claim. These types often come directly also because they feel the need of a lawyer to aid their supposed cause. Then, too, members of the bar direct them to the legal-aid door because they are rarely cases that pay well. Those suffering from delusions of persecution come to the legal-aid lawyer to save them from their imagined aggressors, to erect the barrier of the law about themselves. The fact that emotionally unbalanced people are most apt to get into trouble and to need an attorney is another factor. Finally, there are those bewildered personalities who seek a crutch to lean upon and who seize upon the "counselor" to meet this need. With this material to handle, it is obvious why the legal-aid attorney

should be grounded in at least the elementary principles of mental hygiene.

It should be emphasized at the start that it is not the function of the amateur to dabble in psychiatry. It is often possible, however, for an intelligent observer to help an individual redirect his energies into more constructive channels. At least the worker can refer the applicant to the appropriate agency; or, at the very least, can avoid further damage to the fabric of his personality—in some cases, no easy feat!

To give the reader an idea of the work of the front-desk attorney, a few cases have been selected which illustrate the types of situation handled.

Elizabeth R., a typical American factory girl, aged twenty-two, came seeking an "injunction." She wished to restrain her former "boy friend," Rocky, from spreading slanderous statements about her—specifically, to her new friend, Jack. A sympathetic attitude on the part of the attorney elicited the following facts: Elizabeth had previously been "going steady" with Rocky. While on a "date" with him at a neighborhood beer garden, she was introduced to Jack by his escort, Mary, who was Elizabeth's best friend. The next evening Jack telephoned and asked for an appointment. Elizabeth refused because she did not wish to impair her friendship with Mary. Immediately thereafter, Mary came over and asked why she hadn't accepted Jack's invitation and disclaimed all interest in him. The two then met on the street and had lunch together several times.

Rocky soon learned of this "through mental telepathy" and at once threatened to have Elizabeth discharged from her position, alleging that she was a prostitute. Thereafter he hounded her and eventually succeeded in having her discharged. He was now writing a flood of scurrilous letters to Jack to discredit her in his eyes. What could the Legal Aid Society do to stop this?

The allusion to mental telepathy naturally served as a warning signal to the interviewer, who questioned the girl closely thereon. Inquiry brought out the fact that she heard voices and possessed a whole equipment of prescient faculties. In response to the question, "Have you ever spoken to any doctor about your ability to receive electric impulses?" she proudly told of having impressed several doctors with it. She readily supplied the name and address of the one she had last consulted. The interviewer then explained that in order to handle her complaint properly, he would have to secure a medical opinion on her ability to receive telepathic messages, and he asked permission to get into contact with her physician. The client readily assented and in her presence he telephoned the physician, who at once informed him that the client was a paranoiac with homicidal tendencies whom the hospital authorities had been vainly trying to locate.

In as much as Elizabeth had shown intelligent coöperation in revealing her supposed psychic ability and had evidenced confidence in the physician, it was explained to her how much in her case hinged on this

telepathy and the suggestion was made that she report to the physician for further examination. As the appeal was to the subject's ego, she readily consented, and is now safe in an institution, receiving the care and supervision that her condition call for.

Cases such as this of obvious insanity are not rare; the problem is to secure admission for the client into an appropriate institution. Unfortunately the overcrowded condition of our hospitals for mental diseases is so serious that the client must practically be established as a definite menace to society before an admission can be effected. "Queerness" is not enough. With the percentage of mental cases on the increase, the inadequacy of our budgets for mental hospitals becomes glaring. This is just another problem in mental hygiene that forces itself upon the attention of the legal-aid worker.

Of the same category, William B. came to our office for legal advice. He lived in the suburbs and his well was being "poisoned systematically by the county supervisor"; also he was afraid that he would be put to death because of his "condition." Upon close questioning, he reluctantly disclosed that the "condition" alluded to was syphilis; he would not admit it by that name. Further questioning revealed that soda-fountain clerks also attempted to poison him. Anxiously and pathetically he asked: "Can they give me the chair for it?" The attorney reassured him, but cautioned him that one infected with a venereal disease was forbidden to use public eating places under penalty of very serious punishment. (The man had lesions about his mouth.) B. promised never again to eat in a public place and to report to his local health authority. A check-up failed to uncover the ultimate outcome of the case.

In the more common types of so-called "nut" case, all that an attorney can do is to ease the applicant off as tactfully as possible. Examples of such cases are the formerly well-known actress, now on the W.P.A. Theater Project, who demanded her fifty thousand dollars per week "the same as all the rest of the workers on the project"; the home owner who demanded his constitutional right to appeal to the Supreme Court of the United States against the foreclosure action that resulted in his eviction (this man is a periodic visitor to the office); and the pre-depression banker who talked in fabulous sums of a claim against the Federal Reserve Bank. These people were completely out of gear mentally and their "legal" claims were just one symptom of it.

More subtle abnormality is encountered in connection with the group of border-line cases which rest upon a tangible, factual foundation, but in which the client broods over the facts and has a distorted idea as to the proper emphases to be given them. Such loss of perspective is particularly pronounced amongst individuals who have lost their positions and whose chances of earning a livelihood are accordingly diminished.

An interesting example of this group of cases is that of Anthony B., formerly a clergyman in the Episcopalian Church. B. is an excitable Italian whose habit of translating literally flowery phrases from his native language furnishes humorous interludes. He was formerly a Roman Catholic, but on his arrival in America and subsequent marriage, he decided to become a clergyman in the Episcopalian Church. He was eventually assigned to a parish in a small community on Long Island. He carried on for several years, but ill health overtook him. His increased excitability led to outbursts that reached the ears of his bishop, who demanded and received his resignation.

B. brooded over the situation for six months, making pleas for his reinstatement to the bishop, the President of the United States,[1] and the United States Supreme Court.

B.'s letters revealed how the losing of his position had affected his sense of proportion. He attributed the loss of his job to the "cloaca of the Roman Catholic Church" which had provoked his verbal assaults. B. conceived his illness to have resulted in his death and claimed to have been reincarnated, on the basis of which fact he thought he should be given a new job.

The Legal Aid Society became a satisfactory substitute for the Great Father at Washington, and B. placed all his hopes and confidence on the shoulders of the young attorney. A preliminary investigation disclosed the real circumstances of B.'s resignation, and he was called back for an interview. At the outset he was impressed with the fact that those responsible for his condition had been "put on the carpet" and made to explain their position (a free construction of a perfunctory letter from B.'s superior responding to the attorney's formal inquiry). B.'s self-esteem soared.

Then followed a period of simplified instruction as to the limitations of the courts in the internal affairs of private organizations. B. was made to understand that, however innocent a victim of circumstances he might be, he could not hope to regain the parish. An effort at reorientation was then attempted, the attorney seizing upon a remark as to his previous occupational experience dropped by the client. It was learned that B. had once made an application for a W.P.A. job, and

[1] Legal-aid attorneys soon learn that writing to the President about relatively unimportant private affairs is not necessarily a sign of insanity, but is a very natural act in one not too well posted on community civics who is in search of a parent substitute.

the attorney worked together with B. in trying to push through the application and restore him to his previous state of self-integrity.

Another case of this type was that of Fred J., formerly with the city fire department. J. claimed that he had been dismissed from his post without cause. An investigation of the department files revealed a fifty-page record of the hearing on the basis of which J. had been dismissed. The specific charge was "absent without leave for forty-two days." J. claimed that he had had amnesia during this period and had no recollection of his whereabouts. The implausibility of this explanation was brought out by the referee at the hearing. A consideration that weighed heavily against J. was the charge made by a landlord that J. owed him rent for a period during which he had lived with some woman in this landlord's rooming house. J. was married and had several children. Although the landlord subsequently withdrew his charge, the commissioner holding the hearing indicated that he thought the retraction was a "put-up job" and that J. had committed the adultery charged. Unfortunately no attempt was made to check up on dates.

J.'s claim to amnesia was not substantiated by medical opinion. Bellevue Hospital, which had had him under observation for fourteen days, reported that the amnesia seemed simulated to some degree. A close questioning by the Legal Aid attorney and a careful reading of the minutes of the hearing indicated that J. had had an unhappy marital life and in all probability desired an escape.

The commissioner told J. that he believed him to the extent that he thought J. himself believed in his amnesia. He pointed out that J.'s feelings, however, were the results of wishful thinking, and after balancing the scales of morality against psychology, he decided that the morality concept was the more important and that the amnesia alibi would not go. Whatever one's opinion of such an evaluation from a social point of view, the fact remained that J. did *not* remember where he had been during his period of absence.

After the investigation of the record, J. was called in for an interview and rapport was established by the attorney's joking with him about the voluminousness of his record and his stature amongst the other cases on file at the department. J., previously tense, was disarmed and given a sense of sharing with the interviewer. The latter then patiently went over the high lights of the hearing with him and pointed out the legal sufficiency of the evidence against him. Care was taken to avoid setting up any one upon whom he could center his blame. The commissioner became a cog in the administration of justice; the witnesses, honest citizens. J. was made to see that the law gives relief only upon certain fact set-ups and that neither he nor fate was to blame for his predicament. J.'s feelings were thus tempered, and his antagonistic reaction to what he felt to be a persecution that had resulted in the loss of his livelihood was converted into a determination to start afresh.

It will be noted that the handling of this case differed from that of the case of B. There it was felt that unless some way out were presented to B., a crisis would be precipitated that would probably result in disaster. Hence he was assisted,

at the risk of a crisis at a later date. In the case of J. it was believed that his inherent stability would carry him through, especially if his domestic difficulties were adjusted.

Another instance in which exaggerated reactions followed the loss of a position was the case of G., formerly an employee in the department of sanitation. G., a voluble, good-natured Italian with ten children, was dismissed from the department because of the onset of a respiratory disease. G. was referred by a civil-service association which advised that, from a practical angle, there was little that could be accomplished, but that representation at the department hearing would have a great psychological benefit for G.

The Legal Aid attorney had an interview with G., who came in reinforced by a number of little G.'s of assorted ages. The client exhibited a surprisingly naïve attitude toward the Law along the general line of parent veneration. An understanding of the feeling tones involved in the life experience of this client gave the interviewer a clue to his successful handling. G.'s fundamental problem was one of ego. This was revealed in his patriarchal attitude toward his children as well as in his veneration of the legal process. Accordingly the attorney assumed an aloof attitude of detached importance and gave the impression that the Olympians would intercede on G.'s behalf.

The outcome of the hearing was a foregone conclusion, but G. was made to feel that he had been given a fair trial and before the decision was handed down his attorney pointed out the health hazard for him of continued employment in the same occupation. Efforts were made to secure Workmen's Compensation, eventually resulting in success. By this time G. was prepared for the news that he could no longer continue in the department and accepted it philosophically. His faith in the court system and the government had been vindicated.

The number of adult infants seeking legal aid is large. It is typical of these clients to lay all their troubles on the shoulders of the interviewer, heave a sigh of relief, and expect him to right all their wrongs, real and fancied. In some cases the mere telling of the story by the applicant has a beneficial effect. Usually it becomes necessary to establish a give-and-take relationship between attorney and client and to make the client feel that he is sharing an experience with the attorney. These personalities wish to be taken by the hand and led, but they should be helped to help themselves instead.

An extreme case was that of Catherine O., a thin, nervous lady of about forty who had a claim against a railroad for damage done to furniture in the course of transportation. Miss O. opened the interview with a self-pitying story of her condition and related how uncoöperative the railroad had been about adjusting her claim. At this point she burst into uncontrolled sobbing. Questions calling for factual

responses as to various aspects of her case failed to stop her outburst; whereupon she was told to step outside until she achieved better control. This quieted her at once and she was able to give further details. She handed over a thick sheaf of papers to the attorney, all in disorder. They related to a great variety of matters, and the applicant pleaded that he piece her case together from them, because she could not remember details. She was very nervous and ill at ease.

At this point the attorney reached for a bag of jelly beans secreted in a desk drawer and offered them to the client. She at once broke into a sunny smile and accepted some; the attorney helped himself and left them on the desk for mutual access. Incidentally the jelly-bean bag has since been used as a very successful device on difficult clients, piercing their protective armor where other weapons fail.

Miss O. and the attorney then went over the case, filling in dates, which the client now remembered much more readily. She was made to go through her papers and select those relevant to the case as her part in a game directed against the railroad. Commendable progress was achieved.

The troubles about which applicants consult attorneys are amusing as revelations of the variations in the concept of an attorney's function. Requests include everything from aid in obtaining employment to assistance on love problems. Usually the interviewer is able to refer applicants to the appropriate agency. Vocational guidance is sometimes attempted when it fits into a case already handled for the same client.

One characteristic exhibited by a large number of applicants is the attitude that the law must be precise and positive. Upon reciting a given set of facts, the client expects a conclusion of law directly applicable to the situation. It is hard to make clients understand that the law is not static, certain, and predictable. "If I sue, will I win?" is a question too often asked. This can be partly explained on the basis of the search for omniscience—the vestige of dependence upon parent substitutes.

Various more turbulent mental attitudes displayed by applicants are of significance to the social psychiatrist. The most marked of these is an ostensible ungratefulness exhibited by the client, coupled with an identification of the attorney with any displeasing answer to the applicant's request.

A typical case is that of a perverse old lady for whom the attorney spent twenty minutes of research in the law books, under the pressure of a line of clients waiting outside the door. He patiently explained the various courses of action open to her, none of which met her fancy

in that there was no immediate assurance of monetary recovery. After he was all through, the client burst out; "What did I come here for, anyhow? I just wasted my time, and I'm now no better off than when I came. Please return my fifty cents."[1] From the facts presented, the attorney was given an insight into a life of inadequate income and economic uncertainty and had inklings of the frustrations, conflicts, and personal crises in which the client lived. Her emotional attitude was only a distortion of a militant instinct of self-preservation and was, therefore, not surprising.

The incident just cited furnishes a clue to the most common shortcoming of the amateur mental-hygienist—namely, obfuscation by his own emotions. Without a broad social viewpoint, it is perfectly natural to resent unreasonable personal complaints as a personal affront. But emotionally toned attitudes towards socially unacceptable forms of behavior must be modified and an objective attitude adopted. One must always remember that the labels "good," "bad," "moral," "immoral" mean little without reference to the total situation.

Another common fault of the worker is that of falling into a rut, routinizing the cases until little allowance is made for individual differences. This is often accompanied by a lack of ingenuity in meeting new situations when they arise. The most undesirable feature of this is the interviewer's complete unawareness of his own inadequacy; the same mistaken technique may be repeated endlessly with no realization thereof.

The legal-aid worker shares in an advantage held by the psychiatrist and denied the social-work visitor—the subject comes to him to tell his story and seek help. There is, therefore, less of the reticence encountered by the social worker, for the applicant comes determined to present his case.

On the other hand, the legal-aid worker is handicapped by the briefness of the period he may allot to each applicant. Whereas a psychiatrist has an unlimited number of interviews at his disposal, and the social worker is furnished with reports from several other agencies and may make frequent field trips, the legal-aid attorney must make decisions as he talks, for his contact with any one client may end with the first interview. This calls for the ability to make instant

[1] The retainer's fee.

evaluations and prognoses. As a corollary to this, the interviewer's grounding in social psychiatry will often aid him in deciding whether to accept or to refuse a case. Where the factual basis of a claim is non-existent or the emotional instability of the client will require so much of the attorney's attention that the rest of the case load will suffer, the interviewer is justified in discriminating.

Legal-aid work is not entirely ameliorative. One of the main purposes is to initiate and secure the passage of constructive legislation. One significant contribution may be cited—the passage of the Domestic Relations Court Act, which transformed the remedial agency for adjusting the emotional disharmonies of the family from a criminal court into an informal tribunal surrounded by social workers. This represented a memorable achievement of the mental-hygiene movement in the field of law.

With one out of every twenty-two people confined in a hospital for mental diseases at some period during life and the rate constantly increasing, it is imperative that society place more emphasis on the problems of mental hygiene. A significant contribution may be made here by workers in the various fields of public relations if they have an intelligent understanding of the problems involved. The building of jails and hospitals is an indictment of a society; the problem should be met by removing or at least ameliorating the conditions that give rise to them. The intermediate step is the recognition of mental conditions as they arise in the various walks of life and the application of a dynamic therapy to develop constructively the personalities of the individuals affected.

PSYCHOLOGICAL FACTORS INVOLVED IN THE PLACEMENT OF THE MENTAL PATIENT ON VISIT AND IN FAMILY CARE

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ONE of the primary considerations in the return of the mental patient to normal social life is the proper psychological preparation of the patient himself, of his relatives, and of the community. The failure to provide such preparation accounts in many instances for the short duration and the futility of the visit, the failure of the patient to adjust in the home or in the community, the development in him of increased or of new psychotic difficulties, and the eventual discouragement, through misunderstanding or lack of understanding, of all those concerned in his restoration to normal social life.

The successful extramural placement of a patient, either in the original home or in a foster home, is not the simple procedure of selecting a suitable patient and arranging for his discharge on visit. In addition to dismissing the patient from immediate institutional care, there is the equally, if not the more, important objective of continuing him on visit, of enabling him to adjust himself in the community, and of teaching the community to accept him. A hostile or even an indifferent neighborhood militates against the patient almost as much as do his own difficulties. Accordingly, an absolute prerequisite to the successful placement of the patient on visit consists of a certain preliminary education of the community, leading to the development of social attitudes favorable to the patient, to his difficulties, and to the hospital itself.

For purposes of discussion, the problem of the preparation of the patient and of his relatives for his return to the community may be divided into two approaches. The first of these, which may be termed the *indirect approach,* consists of the development of a socially constructive relationship be-

tween the hospital and the community. The second, which may be called the *direct approach,* concerns the relationships of the hospital and its staff with the patient and his relatives as individuals.

For an adequate discussion of the first method of approach, it will be necessary to consider the hospital, its administration, and its possibilities of so functioning that it may influence the development of a favorable attitude on the part of the community toward the return of the mental patient. It is well recognized that the mental hospital reflects to a large degree the levels, the standards, and the attitudes of the community it serves. But since the hospital is an organized unit of the community, it bears a definite burden of responsibility in the formulation of public attitudes concerning mental disease. Too often the mental hospital serves merely as a custodial institution, to which the patient is brought and in which he is kept while his relatives merely visit him, little or no effort being made to acquaint the public with the aims, the purposes, and the potentialities of the institution. Instead, the lack of hope and the feeling of helplessness engendered in the family by the development of mental disease continue in the attitudes taken toward the hospital, and only the more aggressive of the public ever make the effort necessary to secure an adequate understanding of the entire situation.

At a limited number of state hospitals, in recognition of the need for a concerted effort to educate the public toward the development of a more intelligent understanding of mental disease, and toward increasing the possibilities of placing the patient on visit, a definite effort has been made to draw the public into coöperation with the hospital by informing them of the nature of the institution, its purposes, its goals, and its needs.

The measures used have been various in character. One of the more successful, that which is being employed extensively by the Worcester State Hospital, with which the writer was formerly affiliated, revolves chiefly around a systematic correspondence with the relatives and the friends of the patient. When this measure was initiated, its value was not fully appreciated; but with the passage of time, results have

been secured that more than warrant the relatively small amount of effort required. The first of these correspondence measures is the immediate sending of a general informative letter, worded and typed as a personal communication, to the relatives of the newly admitted patient. This letter anticipates many of their questions, informs them officially of the actual situation, makes a formal appointment for them to visit at the hospital and to interview the physician and the social-service worker, and gives them an opportunity to develop a favorable attitude toward the hospital by virtue of the special interest signified by the letter. Innumerable relatives have expressed a feeling of gratitude for this measure of acquainting them with the hospital and enabling them to realize the definite interest taken in the welfare of the patient. Furthermore, this letter serves to impress upon them the fact that their coöperation with and understanding of the hospital are essential. Judged by the remarks of many relatives and friends, this letter has been of material aid in correcting their misapprehensions of mental hospitals as purely custodial institutions.

A development of this systematic correspondence has been the writing of letters periodically to acquaint relatives with the actual condition of the patient, either favorable or unfavorable, to urge the relatives to make visits, and to recommend various measures on their part which would be conducive to the welfare of the patient and to his readjustment in the home. Relatives, friends, and neighbors of the patient have all expressed repeatedly to the writer and to his colleagues their appreciation of these letters, thereby indicating that there has been an effective growth of public confidence in the hospital and of that favorable attitude on the part of the community which is essential to the successful restoration of the patient to normal social life.

Another measure employed by a number of state hospitals with which the writer is acquainted is the yearly examination of each patient in the hospital for the express purpose of determining his suitability for a home visit or for placement in family care. After this examination, a letter is sent to the relatives of each patient who is found to be suffi-

ciently improved to warrant a trial visit at home, informing them of this fact and making a definite appointment for a conference with the psychiatrist to arrange for such a visit.

Also, the relatives and friends of patients who have neglected to visit at the hospital receive letters tactfully insisting upon such visits and making formal appointments as a measure of compulsion, thereby doing away with the idea that the hospital is a custodial institution whose inmates may be permanently forgotten. Even the neighbors of negligent relatives have expressed their appreciation to the writer and to his colleagues for such letters sent to these relatives to compel them to take an active interest in the patient's welfare. On the research service of the Worcester State Hospital a letter-writing routine was established by which the relatives of every patient were periodically counseled and educated as to how they might be of service to the patient, to themselves, and to the purposes of the hospital. With the help of these letters, systematic appointments were made, interviews were conducted, and adequate arrangements were completed for the extramural placement of patients. Through utilization of this correspondence measure, more than one patient who had not had a visitor for years had the interest of his relatives reawakened, with subsequent placement on visit.

Another comparatively recent measure, which is being adopted increasingly by various hospitals, is the printing of an institutional newspaper. This type of publication has been found, in actual practice, to serve the purposes of acquainting the relatives and the general public adequately with the growth and progress of the hospital and with the establishment of improved services, and of giving them a thorough understanding of their own rôle in the therapy of the patient and in his placement on visit. A frequent experience at these hospitals is the request of friends, relatives, and neighbors of patients' families to be placed on the mailing list of the publication. The hospital newspaper has proved to be a most effective measure in the development of a coöperative spirit with regard to the institutional care and to the extramural placement of the patient, much as the various trade journals serve to promote good will for commercial firms. Further-

more, it is a most effective measure in disseminating educational material, and in correcting the misapprehensions of the public in general regarding the nature and functions of a mental hospital.

Still another method by which a mental hospital can establish a favorable community attitude toward itself and toward its problems is the practice of encouraging the public to visit the hospital and of conducting clinics for the express purpose of giving lay groups a better understanding of mental disease. At Eloise Hospital, with which the writer is now affiliated, this practice of conducting clinics has been particularly developed. The number of clinics held at Eloise for lay groups and organizations averages more than one a week. In addition, a considerable number of public lectures are given by various members of the staff. On these occasions every effort is made to give the public an adequate understanding of what may be accomplished for the welfare of the mental patient, of the problems to be solved, and of the social implications of mental disease. Thus, a foundation is laid for the development of social attitudes favorable to the readjustment of the patient in the community, as well as a better comprehension of the needs and problems of the hospital itself.

To summarize, the *indirect approach* of the hospital to the problem of discharging the patient on visit consists of the development of a proper social attitude in the community toward this problem by various educational measures. These measures are aimed at the promotion of good will toward and of confidence in the hospital, the instruction of friends and relatives of the patient and of the general public concerning the actual nature and purposes of the hospital, the correction of the general misapprehensions concerning mental disease and mental hospitals, and the development of an individual and a community sense of responsibility for the mental patient.

Concerning the second approach, the *direct approach,* to the relatives and to the patient as individuals, one of the first considerations is the actual administration of the hospital in relation to the patient. In the vast majority of hospitals, under the present type of organization, provision is made formally for only two types of patients—the newly admitted

and the chronic institutional type. A few hospitals recognize a third category of patients, the convalescent. But usually so weak is this recognition that it fails to permit the effective differentiation achieved for the newly admitted and for the chronic patient. To clarify this point, just as the hospital needs an admission service and a chronic service, so does it need a convalescent service which would be convalescent in actual practice rather than in name only. Likewise, the convalescent service should be provided with a special staff similar to that which is usually provided for the admission service.

An actual convalescent service, with its own special staff, would constitute a significant force in securing a more rapid and a more successful selection of patients for discharge on visit, as has been the experience at those hospitals which have met this need. At present, in too many hospitals, the question of discharge on visit or of extramural placement of the patient is left to the accident of request by relatives or by the patient himself, or to the chance observations of the physician, already burdened with routine duties, in charge of the general wards, or even to the sheer necessity of making room for new patients. Yet every hospital has a sufficient number of convalescent patients to populate fully more than one ward. A physician whose only duties are the care and supervision of such wards can handle this major problem of discharging mental patients in a decidedly more effective manner than is accomplished by the unsystematic procedures now generally in use. The institution of such a measure would serve to centralize and to organize the problem of discharging the patient either on visit or in family care, and to establish within the hospital a definite responsibility for this important function.

In place of a convalescent service, some hospitals have employed various measures of grading or classifying patients. An example is the grading system reported by Erickson and Hoskins.[1] However, such measures are usually only unsatisfactory substitutes for a convalescent service, since the latter functions more effectively in two particular regards. One of

[1] "Grading of Patients in Mental Hospitals as a Therapeutic Measure," by M. H. Erickson, M.D., and R. G. Hoskins, M. D. *American Journal of Psychiatry*, Vol. 11, July, 1931. pp. 103–109.

these is the psychological effect of such wards, not only upon the patient himself and upon his relatives by virtue of the official recognition of an improvement in his condition, but also upon the hospital staff through the stimulation afforded through realization of specific accomplishment in therapy. The significance of this effect upon the staff in relation to the promotion of psychotherapy cannot be overemphasized. Equally important is the second advantage of a convalescent service provided with a special staff—that it permits the development of organized, continued, and effective psychotherapeutic measures, as well as the adequate preparation of the patient and of his relatives for his return to the community.

Concerning the actual work with the patient and with his family relevant to their psychological preparation for the return of the patient to his home or for his placement in family care, the measures may be divided into two categories. The first is the systematic interviewing of relatives at regular intervals throughout the entire hospital stay of the patient who has a favorable prognosis, or, more practically, throughout the patient's stay on the convalescent ward. The second is the systematic graduation of the duration of the patient's home visits. The practicability of the first procedure may be questioned; but those hospitals which have instituted a definite convalescent service permitting such intensive work have found the difficulties to be more apparent than real. According to the writer's personal experience, only the first few interviews prove to be difficult and time-consuming. Under proper administration, the services of one physician are fully adequate for a minimum of one hundred patients.

The benefits to be derived from this procedure lie in the opportunities that it presents for the education of the public, for the development of good will and understanding, for the securing of more adequate information permitting better psychotherapy, and for the effecting of gradual changes in the immediate home situation to which the patient must return. All of these advantages serve significantly to increase the number of discharged patients, and, of even greater importance, to prolong the period of normal social adjustment for the individual patient.

Placement on visit should not terminate the series of interviews by the psychiatrist with the patient and with his relatives. Rather, they should be continued at periodic intervals determined by the peculiarities of each case. According to the writer's experience and that of his colleagues, the most effective procedure was found to be interviewing first the relatives, then the patient alone, and finally relatives and patient together. Thus, the general supervision of the patient can be directed, immediate problems evaluated and adjusted, and impending difficulties anticipated. The sense of security thereby engendered both in the patient and in his relatives serves materially to further a normal adjustment of the patient and to meet problems which could not be handled otherwise except by the readmission of the patient to the hospital.

The second type of procedure, the systematic graduation of the lengths of the patient's visits at home, is developed in the following manner: The patient who has convalesced sufficiently to warrant being placed on visit is allowed first to go for a drive or a walk with relatives. Perhaps the next week he is allowed to go home for a day. Next, he is allowed to go home for two or three days, and gradually, depending upon the patient's adjustment to the home situation, the visit is increased from a few days to a week or two weeks or even to a month. Upon each return from a limited visit, extensive interviews are conducted, problems of adjustment are faced, and every effort is made to give both the patient and his relatives insight into their particular situations. Finally, the patient is dismissed on an "indefinite visit," with instructions to return at stated intervals to report his progress and adjustment according to the previously discussed system of interviews.

By virtue of this cautious, systematic graduation of the length of visits, with opportunities to discuss adjustment problems as they arise, and to exercise a direct and continuous supervision over the general home situation and the care of the patient, it becomes possible to send out on visit the patient who had previously been unable to adjust at home, and, by obtaining the confidence and the full coöperation both of the patient and of his relatives, to teach him how to make a good social adjustment. This type of procedure implies a

constant, systematic supervision of the patient's daily routine life that can be achieved best on a convalescent ward. Furthermore, such close supervision and intimate contact can serve to exert only favorable influences upon the condition of the patient, which should be the constant aim and purpose of the hospital regardless of the work entailed thereby.

In regard to patients placed in foster homes, an extensive discussion of which has been given by Thompson,[1] the procedure must be slightly different, but the same general psychological principles apply. In the selection of a family-care home, the personalities of the members of the foster family are evaluated in essentially the same fashion as is done in the case of the relatives of patients. A similar evaluation is made of the personalities of the patients already placed in the home. Finally, the type of home is selected with regard for the patient's general cultural level. A detailed discussion of the entire problem of the selection of the family-care home may be found in Crockett's report.[2] Since placement in a foster home renders impractical repeated visits at the hospital for interviews with the psychiatrist, these patients are visited regularly by a social worker, and with equal regularity, but less frequency, by the psychiatrist. In the writer's personal experience, essentially the same procedure in interviewing was followed as with patients visiting at the hospital, with essentially the same results.

Another approach to the successful extramural placement of the mental patient, and one that may supplement, or perhaps to a certain extent be substituted for, the convalescent service, is the establishment of an out-patient clinic—or, more strictly speaking, a parole clinic—as a unit apart from, but integrated with, the hospital itself. Psychologically, the important factor in the separation of the clinic and the hospital into distinct units is the fact that such a separation has the same personal significance for the patient on visit as the convalescent ward has for the institutional patient; it is a form of official recognition that hospital care itself is no longer necessary. Thus the patient is given a feeling of hope, and

[1] "Family Care of the Insane," by C. E. Thompson, M.D. *American Journal of Psychiatry*, Vol. 91, September, 1934. pp. 337–52.

[2] *Boarding Homes as a Tool in Social Case-Work with Mental Patients*, by H. M. Crockett. MENTAL HYGIENE, Vol. 18, April, 1934. pp. 138–204.

is thereby stimulated to utilize the facilities of the clinic to the fullest possible extent as a measure of avoiding a readmission to the hospital, which, to his mind, represents a serious personal mishap. The prevalence of this emotional and forceful attitude on the part of the patient will be readily appreciated by any one who has had experience in such clinics.

In actual practice, the patient and his relatives report at the clinic at definite intervals for systematic interviewing and counseling. The realization that this is the official function of the clinic serves to impress upon the patient and upon his relatives the values to be derived from full coöperation. Furthermore, the patient feels more free to seek advice and counsel on matters for which he would hesitate to disrupt a hospital routine because of their apparently trivial nature. Also, there is not attached to the clinic the same mistaken social stigma that attaches to a mental hospital, a fact that permits a more ready seeking of assistance at the clinic. Already, for example, at the newly established Eloise Hospital Parole Clinic, patients are beginning to express freely their feeling of gratification for the opportunity of receiving further aid from the clinic rather than from the hospital itself, emphasizing this feeling by voicing their sense of personal improvement and achievement in the remark, "I don't have to be a ward patient any more. I'm well enough to go to the clinic now."

Another quotation from patients and relatives may be given to summarize the psychological value of a parole clinic in regard to its specific function in post-institutional care: "Now you can go to the clinic before anything bad happens and get straightened out, instead of trying to get along somehow or other until you have to be sent to the hospital."

In brief, the *direct approach* of the hospital to the problem of discharging the patient on visit depends upon adequate personal attention, given by means of systematic interviews, to the specific problems presented by the individual patient and by his relatives, preferably through the functioning of an adequately organized convalescent service; upon attention given to the community from which the patient comes or to which he goes; upon systematic graduation of the lengths

of the trial visits until assurance is obtained that the patient can continue to adjust on visit; and upon the establishment of some system of organized post-institutional care for the continuance of supervision and psychotherapy, preferably by means of a parole clinic.

To summarize the psychological factors involved in the successful extramural placement of the mental patient, they include the establishment of the hospital in an educative rôle for the instruction of the general public, and of the patient's friends, relatives, and neighbors, concerning the problems of mental disease, and the organization of an effective system for the psychological preparation of the patient for placement on visit, with adequate provision made for post-institutional care to insure the maximum duration and degree of success of the visit by facilitating the patient's adjustment to his situation and to the community and that of the community to him.

BRINGING UP CHILDREN

THEIR HEALTHY EMOTIONAL AND VOLITIONAL DEVELOPMENT *

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ABNORMAL behavior in children is attributed to many and varied causes. Some people believe that it is due to heredity—that the child was just born bad and that there is nothing one can do about it; others think that it is determined by poverty; still others that it is due to the example set by the parents, to bad neighborhood environment, or to feeblemindedness, insanity, lack of religious training, and many other causes too numerous to mention. There is no doubt a germ of truth in each of these views, but the general tendency has been to overemphasize this or that cause to the exclusion of the others. The great error lies in generalizing instead of carefully studying and trying to understand the experiences and adjustments of the particular child in question.

The psychiatrist to-day does not discuss abnormal behavior as such, but concerns himself with a discussion of deviations in behavior. This is because of his realization that no sharp line of distinction can be drawn between normal and abnormal behavior. Most, if not all, of our information about normal conduct and behavior has been gleaned from study of the abnormal. In the beginning it was thought that the ideas and reactions of abnormally reacting individuals were entirely different from those of the normal—as if these abnormalities were strange creatures that had engrafted themselves upon the afflicted individual and had to be routed out by some mysterious means. Little by little, however, the conviction grew that, great as the outward differences may be, there is a close similarity between the underlying mental processes

* Condensed version of an address delivered before the teachers of the public schools of New York City, October 10, 16, 22, 23, and 29, 1935.

of the abnormal and those of the normal. The same mental processes were seen to be operating in the socially well-adjusted child as in the maladjusted one. In both, behavior was found to take place as a result of definitely motivated psychologic processes, the variations reflecting merely differences in motivation and in attendant conditions and circumstances.

The growing awareness that most human behavior that seems to be logical and consciously motivated is in reality the result of inner mental processes of which the individual is unaware—that is, of instinctive motivation—came from this same source. This made it evident that every mental manifestation has some meaning, every action a definite psychologic significance. Nothing is haphazard in the psychic sphere any more than in the physical world; the law of causalty holds true here as elsewhere. Every mental process is, therefore, the result of other mental processes which have preceded it.

The psychiatrist, realizing that the school is an extension of the child's home environment, must of necessity inquire into this phase of the child's life. He does not enter the proper field of pedagogy, but rather seeks to gain necessary information relative to the developing personality of the child, so that he may view the child's total personality in a total environment.

The early education and socialization of the child begin at birth and are carried on in the home until the child is ready to enter the school system. During this period the parent is usually the only teacher that the child knows, for the home is his world. At the age of six he is enrolled in school and enters a new and larger world. The school now takes over to a large extent the function that up to this time has resided entirely in the home—namely, that of socializing the child. The teacher now assumes the major responsibility in molding the personality of the child. She is called upon to act both as moral adviser and as educational director. You as teachers are confronted with the problem of dealing with a group of individuals whose intellects, emotions, and volitions are as varied and as constantly changing as human life itself. These varied and ever-changing emotions of

humanity must all pass through the same mill. The teacher must try to devise a daily routine that will best serve the needs of the greatest number, but she often finds it impossible to meet the individual needs of certain children who do not lend themselves to education on the mass-production plan.

The task of the teacher would be difficult enough were she concerned only with the intellectual side of the child's life, but the teacher who is to play the part of friend and counselor has many other problems to meet. She cannot neglect the child whose emotional life is twisted and warped by unhappy environmental situations, whose lack of interest in his studies is, perhaps, due to fear or worry. She has learned from her own experience that sullenness, resentfulness, deception, and often even the more serious types of delinquency can be understood and corrected only when they are interpreted in terms of the child's experiences and relationships outside the school.

Many of the problems involved are fairly well defined, and it may be only a matter of enlisting parental coöperation in working them out. But there are innumerable other situations, presenting problems that are vague and intangible, which the teacher is called upon to meet daily. New and baffling character traits are constantly cropping up in the various members of the heterogeneous group of the classroom. In one child a friendly, coöperative spirit is replaced by negativism, or perhaps by shyness. Another child becomes tremendously concerned to receive approbation at every turn, while his neighbor develops an attitude of indifference toward praise or blame. One group of pupils is primarily concerned with the objectives for which the group is working, and willing to undergo the hardships necessary to attain the goal; while in contrast to this group are those children who take an interest only in pursuits that give them personal satisfaction.

Such are the responsibilities that the parents turn over to the teacher. It is in relation to these that the psychiatrist can aid her by elucidating the factors that entered into the production of these various types of behavior and so enabling her more readily to cope with them.

The teacher must be so stabilized that she will not suffer a nervous collapse when she finds some obscene note a student

has written. She must appreciate the fact that stealing, lying, truancy, and other asocial types of conduct are not evidences of moral degradation; they are symptoms that occur in the life of many children in the process of growing up. It is the underlying factors that produce these symptoms with which we are most concerned.

The importance of the teacher's maintaining an objective attitude toward the pupil should be emphasized. Dr. Bernard Glueck made this point very clear when he stated: "One of the outstanding conditions which determine success or failure in child-teacher relationships has to do with the question of objectivity of attitude and behavior. Ordinarily, we are apt to be more rational in our relations with our fellows, the more successful we are in maintaining an attitude of objectivity. By this attitude we simply mean the ability to see things as they actually are, and to deal with them on that basis. The opposite of this is the tendency to color and distort events and things in accordance with the particular bias we may be entertaining at the time by projecting onto them our personal feelings."

Psychoanalysis, perhaps more than any other study of human behavior, has given us an appreciation of the importance of the early childhood experiences of the individual. It has shown us how these early experiences lay down the basic character traits of the individual. This does not imply that once those traits have been laid down they are immutable. But it does mean that if we can understand how unhealthy attitudes and habits are formed, we are in a better position to prevent them or to compensate for their presence and so help to overcome them.

Every child is a problem child, for each is born into a world of adults and each has to learn to adjust himself to adults and eventually to become a mature adult. We who raise or care for children know that this is not a simple process and that the child, in the beginning, reacts like a creature of instincts. Problems in the life of the child do not connote abnormalities. The solution of the problem may, however, indicate abnormalities. Stealing, truancy, lying are unhealthy solutions of problems that occur in the early life of the child. This does not mean that nothing can be done

for the child or the adolescent because those early childhood days and experiences are already in the past. Since the child is in the formative period of life, there is much that can be done to unsnarl emotional kinks, to bring about new adjustments. To do this, however, we must have a proper understanding of the child's adjustment to life, which means that we must understand how its emotional life has been built up in relation to those nearest to it, its parents, brothers, and sisters. Psychoanalysis has shown us that other social institutions, such as the school, industry, and society in general, are to the unconscious of the individual merely substitutes for the home. Stealing, no matter where carried out, has to be understood in terms of the unconscious of the individual, carrying out attitudes that properly are directed toward the home and its members. Truancy, when it assumes such proportions as to be considered delinquency, must be understood in terms of the individual carrying out attitudes that the unconscious aims at the home.

The true meaning of the child's act is contained in the child, in his experiences, in his type of reaction to his physical and personal environment. The entire or basic truth is resident in the child, but he cannot be consciously aware of it. The basic truth, the basic cause resides in his habits of thinking, feeling, and acting. These habits of thinking, feeling, and acting are not entirely open to his consciousness. In the deeper layers of his psychic life, they are part and parcel of his unconscious. Psychoanalysis has taught that this unconscious is the reservoir of forces and motives that direct conscious life.

The question then arises, What determines the basic habits of thinking, feeling, and acting? What determines these healthy or unhealthy attitudes and motives? Here we come to the important consideration of the various types of adjustment to life and the factors or forces that bring about a particular type of adjustment.

This process of adjustment begins at birth, and we can say that in the first six or seven years of life lie the origins of the individual's habits of thinking, feeling, and acting. Psychoanalysis has helped us to reconstruct this early period of infancy, when the child possesses only the inherited quali-

ties which he brings with him at birth. The infant is thus in the state in which we erroneously hoped to find him on his entrance into the educational institutions. This tiny infant whom we are discussing is extraordinarily like a newborn animal in all respects, except that he is in a worse position than the animal. Animals are dependent on the care of their mothers only for a short period, at most a few weeks. They then evolve into independent creatures who can get along without further care. It is quite different with human beings. The child remains for at least a year so completely dependent on its mother that it would perish immediately if she withdrew her care.

But even after the expiration of this year of infancy, the child has not attained independence. It does not know how to procure its food, how to support itself, how to protect itself and ward off dangers. We know that almost fifteen years must pass before the human being can completely dispense with the protection of grown-ups and become an adult individual. It is this long period of complete dependence which determines the child's entire destiny. As nothing stands between the child and destruction for the entire first year of his life except the tender care of his mother, we are not surprised when we find this maternal care beginning to play a very important part in his life. The little child feels safe as long as he knows his mother is near at hand, and he shows his helplessness in a feeling of anguish when she leaves him. He needs his mother for the satisfaction of his hunger; she has become a necessity of life. But this relationship soon goes far beyond what can be explained as the striving for self-preservation. We note that the child wants his mother near him and longs for her when his hunger is satisfied and no special danger threatens him. In response to her tender love and care, a bond has been established with his mother which, while still continuing in the direction of his instinct for self-preservation, has become quite independent of this instinct and gone beyond it.

It might seem that, because of this tender relation to his mother, the child would have every chance of a peaceful physical and mental development. He would be completely content if his mother did nothing but feed him, take care of him,

love him. But at this point the external world, for the first time, enters disturbingly into the relationship between the child and his mother. The child now suddenly learns that his mother does not belong to him alone. The family, of which he is only a small part, has other members—a father, brothers and sisters—of whose presence he has just become aware, but who appears to consider themselves fully as important as he thinks himself. They all assert a right to the possession of the mother. One can easily see why the small child regards his brothers and sisters as his enemies. He is jealous of them and wishes them out of the way, so as to restore the original state of affairs, which alone is satisfactory to him.

This jealousy of small children should be regarded seriously. It springs from the same motives as the jealousy of adults, and causes the child the same amount of suffering as we endure in adult life through the disturbance by unwelcome rivals of our relationship to a beloved one. The only difference is that the child is more restricted in his action than the adult, and thus the satisfaction of his jealous feeling goes no further than a wish. He wishes the tiresome brothers and sisters to go away; he would like them to be dead. To the little child, who has not yet learned to grasp the meaning of death, there is, for the time being, no difference between going away and being dead.

The more the child values the possession of the mother, the more violent is this desire. The child is at first single-minded in his hostile feelings. There is no emotional conflict. An emotional conflict arises within him only when he notes that his mother, who loves these disturbing brothers and sisters, requires him to give up his evil desires with regard to them, to share the mother with them and even to love them. Here is the starting point of all the difficulties in the emotional relations between the brothers and sisters of a family. A striking proof of the correctness of the situation here described is that the jealousy between brothers and sisters is much less when the relationship between the mother and her children is not so close. Where the mother is able to give far less care to her children, the loss of tenderness to

the child at the birth of younger children is correspondingly less.

This emotional antagonism in which the little child is involved in relation to his brothers and sisters is a comparatively harmless prelude to another and a much more powerful emotional conflict. His brothers and sisters are not the only rivals who compete with him for the possession of mother; a far more important one is the father. The father plays a twofold part in the little child's life. The child hates him as a rival when his father acts the part of the rightful owner of the mother, when he takes the mother away, goes out with her, treats her as his property, and insists upon sleeping with her by himself. In all other respects, the child loves and admires his father, relies on his help, believes in his strength and omnipotence, and has no greater desire than to be like him in the future. Thus there arises for the child the extraordinary problem, at first quite insoluble, that he loves and admires a person and at the same time hates him. In relation to his brothers and sisters, it was only a question of restraining his evil desires in order to please mother. Here for the first time one emotion is in conflict with another emotion. One can readily imagine the difficulties into which the little child is plunged through this conflict.

I have been describing to you a model family. I wanted to place before you the difficult position of the child, with his conflicting emotions, even when his external environment is favorable. Where external conditions are worse and the family life more miserable, the conflict that goes on within the child is still more severe.

Let us assume that the child is not brought up by his own mother, but during these most important first years of his life is boarded out, first at one place, then at another, or is taken care of in a home by more or less indifferent nurses who are constantly changing. Ought we not to assume that the lack of this first natural emotional bond will have great influence on the whole of his later life? Or let us take it that the father whom the boy regards as his example and in whose footsteps he seeks to follow is a drunkard or insane, or a criminal. Then the effort to become like the father, which normally is one of the greatest aids in education, leads in

this case to the direct ruin of the child. When the parents are separated and each parent tries to win over the child to his or her side, and to represent the other as the guilty party, then the entire emotional development of the child suffers. His confidence is shattered by the too early awakening of his critical powers. An eight-year-old boy, who made vain efforts to bring his parents together, made the remark: "If my father does not love my mother, then my mother does not love my father . . . then they cannot love me. Then I don't want them. And then the whole family is no good." The consequences of such a situation for a child's future development are generally serious. His normal development is checked and he reacts to the abnormal condition in some abnormal way.

Having discussed the emotional development of the child and having seen why he reacts as he does, let us now turn to his volitional development and see how his actions are carried into execution. The drive for self-preservation gives rise to the need for security. The need for security is, therefore, a self-protective mechanism. It is, incidentally, a need that is present in adults as well as in children. During the period of growth, however, the need for security is particularly important. Primarily, the child finds this need satisfied by the care, nurture, and protection afforded by his parents. In many of its aspects, parental care, nurture, and protection are essential to the very life of the growing child and infant. Consequently, anything that threatens the security of the growing child is also a threat to his drive for self-preservation.

Children who do not feel secure may show a variety of reactions or responses which, if called forth repeatedly over a period of time, will pervade the entire personality and result in instability of one sort or another. It should be clearly understood that to the child security means safety, while insecurity means danger. Therefore, whenever danger is present, his desire for self-preservation requires him to protest.

How does the child protest when he feels insecure? Confronted by a danger situation, a situation that threatens security, the drive for self-preservation asserts itself in order

to protect the individual. This assertion takes the form of an emotion or feeling of fear, expressed behavioristically by flight from the danger situation, or of a feeling of anger, expressed behavioristically by fight or aggression, which combats or overcomes the danger situation.

For example, John, who is seven years old, has a marked sense of insecurity because he is openly rejected by his mother and his grandparents. John was born out of wedlock. He was brought home to live with his mother and her parents, who looked upon him as a living and perpetual example of his mother's folly and a disgrace to the family. He was soon told by his mother that he must never call her "mother," that she was not his mother. He was repeatedly reminded by his grandparents that since he was born there had been nothing but trouble in the home. John was brought to see the psychiatrist because his grandparents considered him a bad boy. He was defiant toward them and his mother. He was stubborn and disobedient—flew into rages in which he would scream, bite, and kick, and repeatedly ran away from home.

Sometimes the aggressive, hostile type of reaction to a feeling of insecurity is not so clearly expressed as this. There are some children who repress or inhibit such extremes of behavior and exhibit it in a disguised form. Typical of such children is Joan, who is three years of age. Joan, too, has reasons for feeling insecure. She is an unwanted child whose mother attempted to induce an abortion on several occasions during her pregnancy. For a few days after Joan was born, her mother refused even to hold her. The mother has told the psychiatrist that from the first she had periods when she felt that she actually hated the child. Joan, although a reasonably obedient child in most ways, has found a very successful way of expressing her hostility to her mother. From a very early age she has been an exceedingly difficult feeding problem. Regularly and consistently after every bottle feeding she regurgitated. From the time she was weaned, she has never taken a mouthful of food unless it was forced down her throat by her mother. The dining room is regularly a battleground where Joan and her mother meet three or more times a day. Joan keeps her teeth and lips

tightly closed until her mother eventually succeeds in prying open her mouth and forcing food down her throat. Feeling runs high on both sides, with mother gritting her teeth, becoming red in the face and highly excited, and with Joan screaming between spoonfuls of food, biting, pinching, slapping, and kicking whenever her mother fails to restrain her. Incidentally, Joan always come out the victor by putting her finger down her throat and regurgitating most of the food which mother has succeeded in getting into her. Except at mealtimes Joan is a nice little girl, as even the mother is willing to admit.

Then there are children who tend to react to feelings of insecurity with timorous, shy, nervous, self-conscious behavior. Stanley, for instance, is a seven-year-old boy who can never predict his mother's attitude. At one moment she is gushing, overaffectionate, and smothering him with caresses, while the next she is irritable and cross and upbraids him unmercifully. Stanley naturally finds it difficult to determine just where he stands with her. Stanley presents the typical picture of what we think of as the nervous child. He is reticent, unduly respectful, always says, "Yes, sir," and "No, sir," stands at attention, is afraid to play with other boys, wants to stay home with mother, and has crying spells every day before it is time to go to school. Now and then he stammers in a nervous fashion. Quite often at night he wakes up from a frightful dream.

Children find their security both in their environment and within themselves. A mental or physical handicap in a child may cause that child to feel insecure because of his inadequacy, or because his handicap is such that it prevents him from being accepted as a member of the group. Thus, Lillian, a nine-year-old girl, who has a mentality of about seven years, is very nervous and tense. She feels insecure because she is compared unfavorably with her six-year-old brother who is quite bright, and because she is scolded for her slowness in learning. Thus she feels that she is rejected by her mother. In spite of her efforts to mix with the group, she finds herself merely on the fringe of it and has many unhappy moments because she cannot quite belong.

Any situation in the environment that threatens a child directly or indirectly, or that makes him feel that he is not wanted or is not a part of the group, will evoke a sense of insecurity. It must be remembered that a sense of security must be built up within the child himself. Although at first the infant derives his feeling of security from the protection afforded him by those about him, this sense of security will remain dependent on such extrinsic factors unless he is given the opportunity, through training, to develop a feeling of security within himself, or, in other words, a feeling of self-reliance. Therefore a life shielded and protected at every turn from infancy onward will result later on in a feeling of insecurity in the child whenever protection is removed, or whenever he is removed from it.

Thus we see that training, be it good, bad, or indifferent, starts from the day the child is born. Babies who learn that they can get what they want by emotional protests may continue the pattern throughout their entire lives. They may grow up to be self-centered individuals who often resort to childish emotional tricks to get what they want when they want it. It is on this principle of training that children learn to regulate their behavior.

At the beginning of this learning process, the parent acts as the censor of the child's behavior. As time goes on, however, the child develops his own capacity for censoring or controlling his behavior. In other words, he develops what we commonly call a conscience, which is usually far more strict and far more efficient than any restrictions existing outside of the individual. This whole problem of training is not so simple as it seems. The best training in the world is likely to prove ineffective if it is not associated with or permeated by a healthy interplay of emotions between the parent and the child. As a matter of fact, the wise parent is one who utilizes the natural love of the child to induce him to accept the restrictions necessary as a part of the training procedure.

When the infant or growing child is rebuffed by indifference or open rejection from those with whom he is attempting to establish an emotional relationship, he is apt to remain

essentially a self-loving or egocentric individual, because his efforts at being otherwise consistently meet discouragement. Thus, James, who is five years of age, was unfortunate in having a mother who did not have much affection for him and who repulsed his childish efforts at showing his love for her. Now at the age of five he is rather indifferent and apathetic, and shows no desire to play with other children; he keeps largely to himself and spends most of his time in kindergarten in daydreaming, and his greatest source of pleasure seems to be in the infantile habit of sucking his thumb.

Parenthood is an obligation to society as well as to the child. It can be met only by molding the child into a social being. It is tremendously important that parents make every effort to understand the motives behind the thinking, feeling, and acting of their children, for motives are the fundamental matter rather than the conduct itself. It is equally important that parents do not try to project into the lives of their children their own unfulfilled wishes and desires, whether associated with their demands for affection, their strivings for education, or their social ambitions. Keep in mind that the child has a personality of his own, and that he should have the opportunity to develop along lines that are suited to his particular individuality.

More than comfortable living conditions and good physical care goes into the making of a home atmosphere conducive to the child's normal development. Less obvious, but no less serious difficulties may be related to personal maladjustments and to biases in parents and others who are intimately a part of the family circle. A case in point is the intelligent mother who overprotects her child even while aware that overprotection is undesirable for the child's development. The problem here is, What is there in such a mother's own personality or psychology that compels her to act against her better judgment and not in accord with the best interests of the child?

Some parents are themselves still children in their attitudes toward life, and require treatment in order that they may fulfill their personal responsibilities. We often see such

parents bickering and quarreling with their children instead of offering the leadership and guidance that the children need.

Then there are the problems of incompatibility between the parents, with one or the other parent devoting his or her life to the child as a sort of solace for disappointment in the mate.

We all know, too, the parent who dominates and controls the entire life of the child. There is, for example, the father who was unable to fulfill his ambition to become a doctor and who seeks to realize his own frustrated aspirations by requiring his son to study medicine. And there is the mother who, feeling inadequate because of her own meager education, is especially critical of her daughter's scholarship at school and constantly urges her to do better work.

We see parental rejection at work every day. Parental rejection—*i.e.,* a situation in which the parents do not want or do not love a child—may be expressed directly and openly and consistently, the mother or father showing no love and no interest in the child at any time. It may also present a picture almost the opposite of this. The rejection may be largely unconscious and covered by a compensatory oversolicitude. Such parents are overprotective of their children and overconcerned about them. Whenever a parent expresses constant fears of the child's being hurt or becoming ill or dying, one is entitled to wonder to what extent these fears indicate an unconscious, yet real wish.

Usually parental rejection is not consciously appreciated by the parents and is based upon a variety of unconscious reasons. Mrs. Jones, for instance, is very severe and critical toward John, because she does not like him. She does not like him because he reminds her of his father, who deserted her two years ago after several years of marital incompatibility. Then there is Mrs. Smith, who is very solicitous and overprotective of Mary and frequently has fears of her getting injured or killed. Mary's father is twenty years older than her mother, and Mrs. Smith often says that he seems more of a father to her than a husband. Mrs. Smith now has to share with Mary her husband's love, and she is distinctly jealous of her. Neither Mrs. Jones nor Mrs. Smith con-

sciously knew or understood, before treatment was undertaken, what was really going on in their minds about their respective children. Mrs. Jones knew only that she was overcritical of John, and Mrs. Smith knew only that she worried too much about Mary. Both realized that they were at fault and both said that they had tried to correct their attitudes, but somehow had not been successful. Here we see that parenthood does not endow one with maturity and a well-adjusted personality. It becomes evident that these parents carried over into parenthood unsolved problems from their own childhood which strongly determined their attitudes and reactions toward the child. In many respects these parents were unconsciously reënacting with the child conflicts that had never been solved in their own childhood. The excessive strictness and the overindulgence of these parents and their harmful influences on the children had their origin in the personality problems of the parents themselves.

I have tried to point out to you the mental conflicts that go on in the minds of these children. Warped and twisted are many of their views on the problems of everyday life with which they are constantly being confronted. Pathetic as it may be, in the hustle and bustle of our day's work, we do little to help them; often with the best intentions we make grave mistakes. But much good can be accomplished and much harm avoided if the teacher will appreciate that the emotional life of the child is quite as important as the intellectual life, and that a good intellectual equipment is of little value to an individual if he is handicapped by bad habits of thinking, feeling, and acting, manifested in feelings of inferiority, jealousy, and fear, or in resentment and defiance toward those with whom he comes in contact.

To be of the greatest value, the teacher must really know the pupil—not only his intellectual capacity, but his instinctive and emotional life, his joys and sorrows. An effort must be made to determine the motives that thwart and inhibit the child and the means by which he may be stimulated to an honest effort. The child must not look upon the teacher as a dictator, but as an adviser and counselor in time of trouble.

Throughout this paper I have endeavored to indicate how important a rôle is played by the adults in the child's immediate environment in shaping his destiny and in determining his degree of fitness for the business of living. This implies a serious obligation as well as a fine privilege and opportunity for those of us who have the rearing and education of children in hand—opportunities and obligations of which the mental-hygiene movement is aiming to keep us aware.

BEHAVIOR PROBLEMS OF CHILDREN FROM HIGH AND LOW SOCIO-ECONOMIC GROUPS *

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CONSIDERABLE attention has been given in recent years to the behavior problems of children from families of low socio-economic status. Less study, however, has been devoted to the problems of children from more comfortable homes. This is understandable enough. The rich are better able to solve their own difficulties. The problems of the poor, on the contrary, are more likely to be referred to social agencies and thus come to the attention of research workers.

The principal object of the study reported on here was to investigate the characteristic behavior difficulties of children of the higher socio-economic group. For this purpose fifty case histories of children from "comfortable" homes were selected from the files of the Washington Child Guidance Clinic. To throw into relief the factor of socio-economic status, a control group of fifty children from "dependent" homes were selected from the same source. The classification of socio-economic status was determined by a scale devised by Mary Augusta Clark, of the Commonwealth Fund Statistical Service.

The children were matched for sex and, as nearly as possible, for age. Twenty-two of them were girls, 78 boys. About 60 per cent of them were from eight to fifteen years of age at the time of reference to the clinic.

These children presented a total of 355 behavior problems, which were classified according to a system formulated by Dr. Paul J. Ewerhardt, Director of the Washington Child Guidance Clinic, as (1) habit problems, (2) aggressive per-

* Based on material gathered by the writer while a student at the National Catholic School of Social Service and forming the basis of a master's dissertation, Catholic University of America, 1936. The full dissertation is on file in typewritten form in the university library.

sonality problems, (3) submissive personality problems, and (4) educational difficulties.

These four categories will be considered separately.

Habit Problems.—The two groups were very much alike in the distribution of occurrences of faulty habits. The greatest difference was in the matter of sex experience, five of the children in the dependent-class or control group presenting this problem and but one child in the experimental group. It is interesting to note that there were more "eating difficulties" among the children of the dependent group than among those of the comfortable class. The five cases presented by the children of the poor varied from a child who ate grass and gravel, and another child who was considerably underweight and yet refused to eat anything, to a child who grossly overate.

Aggressive Personality Problems.—Stealing was the conduct problem of most frequent occurrence in this category. It was noted in two girls and five boys in the experimental group, and in twelve boys in the control group. "Stealing" varied all the way from occasional appropriation of siblings' clothes and taking change from mother's purse or miscellaneous articles from schoolmates and the Ten Cent Store to more serious offenses, such as stealing an automobile or forging a check. There were two instances of stealing an automobile—one in the control and one in the experimental group. The other children in the comfortable class confined their pilferings to "taking money from mother's purse and odd things from schoolmates." On the other hand, children in the dependent class, in all except two instances, extended their acquisitive activities to their neighbors' houses, the grocery store, and Woolworth's. With the exception of two children who were eight years old, the problem of stealing was presented by children from the eleventh to the sixteenth year of life.

Next to stealing, truancy, running away, lying, bullying, and teasing appear most commonly. In this group, truancy appeared to be exclusively a boy's problem. Eight of the truants were between eleven and sixteen years old. The other three were seven, eight, and nine years of age, respectively. The boys explained their truancy on the following grounds:

six of them either disliked their teacher or did not like the school they were attending; four were completely indifferent to school; and one little fellow said he was looking for his father, who had recently been sent to prison. While the one case in the experimental group came from a home of superior cultural advantages, the ten cases in the control group were all characterized by unhappy family situations. Of these ten cases, there was only one family in which the parents were living together.

Lying, usually of a protective character, increased with the age level among both boys and girls up to fourteen years of age.

Submissive Personality Problems.—In contrast to the aggressive type of person, who seems to defy authority, the submissive child is usually overdependent upon adults and on the protection routine. There was a slight increase in the number of occurrences in the experimental group, indicating that it should not be assumed that because of family means, the intangible qualities of the home are adequate. From the case histories of the children who manifested submissive traits, it was found that parental interest, affection, or solicitude were as lacking in the one group as in the other.

The control group presented twice as many aggressive personality traits as the experimental group, while there were a greater number of submissive traits in the experimental than in the control group.

Educational Difficulties.—This category showed the lowest incidence of any of the groups of behavior traits included in the study.

"Poor school work" was noted in more instances than any other problem under this heading. Lack of concentration, lack of interest in school work because of faulty classroom placement, indifference in school work, and reading disabilities were associated most frequently with this difficulty. While in the experimental group thirteen of the children who were referred because of poor school work were given an I.Q. of 105 or better on the Stanford-Binet scale, the seven children in the control group all had scores below 91. One child in the experimental group who had achieved a score of 154 on the Stanford-Binet test explained his failure in school on the

basis of his objection to the regularity of the studies, home work, and the routine of classroom recitation. One child in each group refused to go to school: a girl, ten years and seven months of age, in the experimental group, who was very sensitive, restless, and "nervous"; and in the control group a youngster seven years and three months of age, whose score on the Stanford-Binet test gave him an I.Q. of 75, who would not go to school because he did not have adequate clothing.

SUMMARY

A group of fifty children from homes of high socio-economic status who had been referred to the Washington Child Guidance Clinic were studied in comparison with a control group of fifty children from dependent homes from the same source.

Some of the outstanding differences between the two groups were that children from the more comfortable homes showed more school maladjustments, more problems based on "submissive" traits, fewer problems based on "aggressive" traits, and about an equal number of "faulty-habit" problems.

TRENDS IN MENTAL DISEASE*

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IN this country at the present time the great majority of patients with serious mental disease are housed in magnificent state or federal hospitals built especially for their treatment. The rapid increase of patients in these institutions during the past three decades, together with the enormous cost involved, has raised anew the questions many times propounded: Is mental disease increasing? Will the whole population ultimately become insane?

In attempting to answer these questions, we have both known and unknown factors to consider. We have at hand practically complete, accurate data concerning mental patients in hospitals—data much more comprehensive and reliable than exist with respect to patients in general hospitals—but we have no reliable data relating to mentally diseased persons in the community. When the question of the increase of mental disease is discussed, it is customary to deal with both the known and the unknown and to stress the one or the other in accordance with the result desired. This has the advantage of always leaving the matter open for further discussion. In this brief paper, however, we shall forego the pleasure of revealing the unknown, and shall confine our attention to the data furnished us by statisticians. We shall, therefore, consider only trends in hospital cases of mental disease. We shall deal with mental patients as a single group and also with some of the principal psychotic groups.

Basic data for our consideration are found in federal census reports and in the statistical reports of state departments. We shall summarize the data and then discuss their significance.

* Read at the annual meeting of the American Sociological Society, Chicago, December 28, 1936.

Enumerations of the insane in the United States have been taken at intervals since 1850. The results for 1850, 1860, and 1870 (obtained in connection with the general censuses of population) are generally considered seriously defective, however. The first census of the insane to which one may attach reliability is that of 1880, which showed 40,942 patients in hospitals for the insane, and 51,017 outside such institutions. The latter total was obtained by circularizing physicians throughout the country. There was, therefore, a total of 91,959 insane enumerated in 1880, representing 183.3 per 100,000 general population. Ten years later, in 1890, those enumerated in institutions had increased to 74,028, but the total of those counted outside such hospitals was reduced to 32,457, giving a grand total of 106,485. The rate per 100,000 population decreased from 183.3 to 170.0. Succeeding censuses of the insane were based only upon patients in hospitals for mental disease. No efforts were made to enumerate such patients outside of institutions. Nevertheless, there has been a remarkable growth in the known number of patients with mental disease. In 1904, there were 150,151 patients in institutions for the insane, more than twice the corresponding total in 1890. In fact there were more patients in institutions in 1904 than were counted both within and without institutions in either of the preceding censuses. The institutional population alone provided a rate of 183.6 per 100,000 population in 1904, compared with total rates of 170.0 and 183.3 in 1890 and 1880, respectively. In 1910 and 1923, the institutional populations had grown to 187,791 and 267,617, respectively, the corresponding rates being 204.2 and 245.0.[1] The latest available census data show a total of 403,519 patients in hospitals on December 31, 1934, providing a rate of 317.5 per 100,000 general population.[2]

Unfortunately, the latest census report concerning mental patients gives complete data by states only for state hospitals. We have, however, comparative data for all states covering the period from 1880 to 1923. Notable increases in rate of

[1] These data are summarized in the United States Census Bureau's publication, *Patients in Hospitals for Mental Disease, 1923.* Washington: Government Printing Office, 1926. p. 11.

[2] *Patients in Hospitals for Mental Disease, 1934,* issued by the United States Bureau of the Census. Washington: Government Printing Office, 1936. p. 3.

patients under treatment occurred in every state during this period. The rate per 100,000 of population increased in New York from 158.9 to 382.6; in Massachusetts, from 173.0 to 399.0; in Illinois, from 71.3 to 284.4; in North Carolina, from 19.2 to 139.3; in Oregon, from 149.9 to 328.4. The 1934 census report which gives data by states only for state hospitals shows a large increase in rates since 1923 in nearly every state.

From these data it is evident that known patients with mental disease are rapidly increasing.

A different view of the problem is obtained by considering the incidence or occurrence of mental disease. Here again are the known and the unknown cases. The known are those that appear as voluntary or committed first admissions to hospitals for mental patients; the unknown are those who develop mental disease and are privately cared for in homes or in institutions other than public or licensed private hospitals.

In federal censuses first admissions were first separated from readmissions in the 1923 census report of hospitals for mental disease. We must, therefore, limit our comparisons from federal sources to the data given in the reports for the years 1922 and 1934. In the former year the first admissions to hospitals for mental disease in the United States numbered 73,063 and in the latter year 96,933; the rates per 100,000 of population were 69.5 and 77.1, respectively.

In New York State reliable data concerning first admissions to all hospitals for mental disease have been compiled annually since 1909. In that year the rate of first admissions per 100,000 of population was 65.1. After 1909 there was a generally rising trend to 1917, when the rate reached 73.9. During the war and the years that followed down to 1924 the rate declined until it reached 67.8. In 1927, a notable rise in rate occurred, and since that year the trend has been upward. In 1935, the rate was 85.8 as compared with 67.8 in 1924 and 65.1 in 1909.[1]

Thus far we have presented data relative to mental patients as a whole. We now turn to a consideration of trends in some of the psychotic groups. In the standard classification of

[1] Forty-seventh Annual Report of the New York State Department of Mental Hygiene, p. 173.

mental diseases 21 groups of psychoses are distinguished. Several of these groups are subdivided into types and subtypes. The various groups differ from each other in origin, symptoms, course, and outcome. The groups of mental diseases associated with disorders or toxic states of the central nervous system or other organs of the body are termed organic in contradistinction to the functional groups, which apparently are not dependent on or associated with physical disorders.

Among the organic cases are (1) those arising from accidents in which the brain is injured, (2) those caused by hardening of the arteries of the brain, (3) those due to the germs of syphilis and epidemic encephalitis, (4) those due to tissue changes associated with old age, and (5) those resulting from excessive use of alcohol and drugs.

Most prominent among the functional mental diseases are dementia praecox, manic-depressive psychoses, paranoia and paranoid conditions, and psychoneuroses.

In discussing trends in the various groups we shall refer principally to New York State data, which cover twenty-six years.

Rapidly rising trends are noted in some of the organic groups. The extension of the use of automobiles has been accompanied by an appalling increase in accidents, injuries, and deaths. In many of the injured persons the nervous system suffers great damage. As would be expected, the traumatic group of mental diseases has notably increased. Prior to the common use of the automobile the group was very small and only in recent years has it come into prominence. In 1920, among the first admissions to all civil state hospitals for mental disease in New York State, there were only 17 traumatic cases; in 1935, there were 135. This upward trend is likely to become more pronounced as automobiles become more powerful and the use of machinery more extensive.

Striking increases have occurred in recent years in the new cases of mental disease due to hardening of the arteries. In 1912, new cases with cerebral arteriosclerosis admitted to civil state hospitals numbered 166. In 1920, the number had increased to 513; in 1925, to 737; in 1930, to 1,290; and in 1935, to 2,281. During the period from 1912 to 1935, the rate of first admissions in this group per 100,000 of population increased

from 1.8 to 16.3.[1] The group known as senile psychoses, which is due to changes in brain tissues associated with old age, has shown a practically level trend from 1909 to 1935.[2] It is possible that some cases formerly designated as senile psychoses are now classified as psychoses with cerebral arteriosclerosis. If this change in classification has occurred, it has not resulted in a declining trend in the senile group.

One of the best known forms of organic mental disease is general paresis, which is primarily due to syphilis of the central nervous system. The prevalence of general paresis is closely related to the prevalence of syphilis in the population, but usually a period of from five to twenty years elapses from the time of the primary infection to the onset of general paresis. Consequently a considerable lag is to be taken into account in comparing the incidence of primary syphilis with the onset of general paresis. Happily the beneficial effects of the measures taken by health authorities for the prevention and early treatment of syphilis are now seen in the declining trend in general paresis. The rate of new cases for this disorder admitted to the New York civil state hospitals has gradually declined from 1918 to the present time. In the former year the rate per 100,000 of population was 9.1 and in the latter, 7.0.[3] A continuous decline from this dread mental disorder may be expected, until syphilis is finally eliminated.

The organic mental disease most widely known and most frequently discussed is the alcoholic psychosis. This mental disorder is directly due to the excessive use of alcohol, but as a rule the onset of the psychosis does not occur until after a long period of overindulgence. Any effective social measures for the reduction of excessive drinking would cause a decline in alcoholic mental disease. On the other hand, any action taken by society that would result in more excessive drinking would cause a rise in the trend of the mental disorder.

In New York State the rate of new cases of alcoholic psychoses admitted to the civil state hospitals was nearly constant from 1909 to 1913. Beginning in the latter year, a notable decline in trend occurred which lasted but a short

[1] *Ibid.*, p. 182.
[2] *Ibid.*, p. 181.
[3] *Ibid.*, p. 183.

time, as the rate in 1917 was practically the same as that in 1913. After 1917, the rate notably declined, reaching a low point in 1920. From that year until 1927 there was a gradual rise in trend. From 1927 to 1932, the rate remained nearly constant. From 1933 to 1935 an upward trend was in evidence.[1]

Contrary to popular opinion, habit-forming drugs are not prominent as causes of mental disease. The number of cases of drug psychoses admitted to the civil state hospitals of New York in 1909 was 24, and in 1935, 30. The annual rate is now slightly above two per million of population and is not increasing.[2]

Dementia praecox is the most prevalent form of functional mental disease treated in hospitals. It is believed that cases of psychoneuroses may exceed those of dementia praecox, but most of the mild cases of psychoneuroses in the community are not serious enough to require hospital treatment.

Dementia praecox constitutes one of the largest health problems with which the state must deal. The disorder frequently occurs in early life and persists until old age. Patients with this disorder constitute more than one-fifth of all admissions and more than one-half of resident hospital patients in New York State. The trend in this disorder in New York State since 1910 has undergone a gradual, but significant rise. The rate of new cases admitted to the civil state hospitals has increased from 9.8 in 1910 to 21.7 in 1935.

The number of annual first admissions during this period increased from 895 to 3,031.[3] No effective means for the prevention of this disorder have been devised.

Manic-depressive psychoses constitute another prominent group of functional mental diseases. The trend in this group in New York State from 1909 to 1919 shows a gradual rise. Since 1919, the rate of annual admissions has varied from year to year, but without showing any distinct upward or downward trend.[4]

Included in the groups above mentioned are more than

[1] *Ibid.*, p. 184.
[2] *Ibid.*, p. 185.
[3] *Ibid.*, p. 187.
[4] *Ibid.*, p. 186.

three-fourths of the new cases coming to the state hospitals. Variations in some of the small groups occur, but they have little effect upon admissions as a whole.

On the basis of the preceding data, we appear justified in concluding that the incidence of mental disease (exclusive of general paresis) has increased in recent decades. Nevertheless, there is a large group of observers who dispute this inference, and who insist that we are confronted, not with an increase in mental disease, but with a growth in the proportion of such patients who are admitted to hospitals for treatment. As relates to the nation at large, there is probably a substantial basis for the latter view. It is known that in many sections of the country provisions for the hospital treatment of patients were formerly very inadequate. But there has been marked improvement in this respect in recent years. As a result it is impossible to estimate what percentage of the increase should be ascribed to building operations and changes in hospital capacity, and what percentage should be attributed to a genuine increase in the number of new cases of mental disease.

But this objection cannot be maintained with respect to the statistics for New York State presented in the preceding sections. In this state we have a long history of state provision for the insane, going back almost a century to the creation of the Utica State Hospital. During this period there has been a steady increase in the incidence of mental disease. Because of the necessity for constant additions to the number of state hospitals caring for the insane, this growth has received close attention from fiscal and legislative authorities. It was maintained at first that the growth in the number of patients was merely a reflection of the increase in accommodations, with the implication that in time, as all the insane were received in hospitals, there would be an end to the annual increase in the rate. Unfortunately, aside from minor fluctuations in the rate, there has been no such stabilization and the rate has continued to mount. Of course, cases of mental disease arise each year which are not admitted to hospitals, and which, therefore, are not included in official statistics. But there can be no doubt that we have reached a point at which the ratio of the number of registered cases of mental disease to the

total number of such cases has become stabilized, so that for practical purposes we are justified in reasoning as to the prevalence of mental disease by a consideration of the ratio of registered cases to the general population.

Objections to the implications of rising rates of first admissions are made on demographic grounds. Chief of these is the stressing of the factor of age. Mental disease rises rapidly with age, and the rate of increase is especially sharp at the older age levels. Since the general population is slowly aging, it is argued that we are now selecting our patients from those age groups in which the rates of mental disease are high. In other words, it is implied that the specific age rates are constant, but that selection within the general population has brought about an upward shift in the trend.

It is true that the population is aging, but the change has not been as great as many believe. For example, those aged sixty years and over constituted 7.2 per cent of the population of New York State in 1910. In 1920 the percentage grew to 7.7, and in 1930 to 8.5. Thus, though there is indication of an increase in the proportion of the aged, the amount is hardly sufficient to have brought about the significant increase in rates of first admissions with mental disease. Complete proof is seen in the following: In 1909–1911 the average annual rate of first admissions to all institutions for mental disease in New York State per 100,000 population aged fifteen years and over was 82.4. If the population of New York State had been distributed in the same sex and age ratios as in 1910, the average annual rate for 1919–1921 would have been 88.0. Again assuming the same age and sex distribution as in 1910, the average annual rate for 1929–1931 would have been 91.7 per 100,000 population aged fifteen years and over. In two decades, therefore, the standardized rate had increased by 11.3 per cent.

Another demographic factor related to the prevalence of mental disease is the urban-rural ratio of the population. It has been demonstrated that mental disease is much higher in cities than in the country. In 1933, for example, there were 68.3 first admissions to state hospitals in the United States from incorporated places having a population of 2,500 or more, per 100,000 of corresponding population, and a rate of

34.6 for all places with a population of less than 2,500.[1] Any shift in population from country to city would, therefore, tend to increase the incidence of mental disease. In fact, such a shift in population is sometimes advanced as one of the reasons for the upward trend in mental disease. Closer analysis, however, will show that increased urbanization cannot be the complete explanation. In New York State, for example, the urban population constituted 82.7 per cent of the total in 1920, and 83.6 per cent in 1930. This slight increase could hardly be a decisive factor in the increase in mental disease. Furthermore, the rate of first admissions has increased among both urban and rural populations since 1920. It is evident, therefore, that the increase in the general rate cannot be considered an artifact of the process of urbanization.

One further demographic factor may be considered—namely, the proportion of the foreign-born whites and the native whites of foreign or mixed parentage. Both groups have higher "crude" rates of first admissions than native whites, the foreign-born having the highest rate. Any increase in the proportions of the foreign stock would, therefore, result in a corresponding increase in the general "crude" rate. This explanation cannot hold, however, for New York State, for the foreign-born whites have decreased from 29.9 per cent in 1910 to 26.8 in 1920 and 25.4 in 1930. Native whites of foreign or mixed parentage increased from 33.0 per cent in 1910 to 35.8 in 1920, but decreased to 35.6 per cent in 1930. Other things being equal, such changes should have resulted in decreased rates of first admissions, whereas we found a rising trend.

We must conclude, therefore, that neither changes in the public attitude toward hospitals for mental disease nor demographic changes in the population can account for the increase in mental disease in recent decades.

To what, then, may we attribute the increase in mental disease? In the previous discussion it was shown that three groups of psychoses were largely responsible for the upward trend in mental disease—psychoses with cerebral arteriosclerosis, alcoholic psychoses, and dementia praecox. The causative factors are well known in the case of the first two.

[1] *Patients in Hospitals for Mental Disease, 1933*, issued by the United States Bureau of the Census. Washington: Government Printing Office, 1935. p. 46.

Hardening of the arteries, associated with the aging process, is a strictly medical problem which may in time yield to medical advance. Prevention of the alcoholic psychoses, however, is largely a social problem. If excessive drinking is discouraged, there will be a decline in the incidence of the alcoholic psychoses. Social attitudes which encourage prolonged drinking will, on the other hand, cause a continued increase in these disorders. We cannot state with definiteness what will be the future direction of social attitudes with respect to alcohol, but there is clearly a large field in which preventive endeavors may be undertaken. The great unsolved problem in psychiatry, however, is that of dementia praecox, a disorder of largely unknown origin. In the absence of a sound knowledge of causation, prevention is a difficult matter. We do know, however, that dementia praecox is a disorder whose beginnings frequently appear in early life. Premonitory signs are often seen in school years. Our hope is that early recognition, and sympathetic guidance through contacts with mental-hygiene clinics, may prevent the development of mental trends which lead to the disorganization characteristic of dementia praecox.

In the prevention of mental disease, we must seek the collaboration of medical, psychological, and social science, and the most encouraging aspect appears to be the willingness—in fact, the eagerness—of exponents of these three fields to unite their efforts in the search for sound mental and physical health.

BOOK REVIEWS

THE THEORY AND PRACTICE OF PSYCHIATRY. By William S. Sadler, M.D. St. Louis: The C. V. Mosby Company, 1936. 1231 p.

In this encyclopedic volume, Dr. Sadler has approached his subject with the purpose not only of appealing to the psychiatric specialist, but also of supplying a helpful background for the general practitioner and the non-psychiatric specialist. As stated in his Preface, his aim is "to divest mental hygiene of its psychiatric mysteries and deliver it from the 'confusion of tongues'—the sectarian clamorings—that have served so to obscure the 'common-sense' methods of study and practice which the rank and file of the profession are well qualified to undertake if they are once delivered from the 'mystifications' of the multifarious teachings of the conflicting specialized schools of psychiatry." This is a large order.

The book has 77 chapters, grouped into five major parts: (1) *The Theory of Psychiatry,* which discusses medical psychology, mental mechanisms, the unconscious and the subconscious, general psychopathology, symtomatology, classification, methods of examination, etc.; (2) *Personality Problems*—thirteen chapters devoted to a comprehensive and varied presentation of the problems of personality, classification, maladjustments, the growth and development of the personality, mental mechanisms, etc.; (3) *The Neuroses,* with twenty-two chapters dealing with almost every aspect of the psychoneurotic states; (4) *The Psychoses,* in which eight chapters are devoted to a discussion of the psychoses, largely from a descriptive and interpretive point of view; and (5) *Psychotherapeutics,* which contains twenty chapters.

Sadler sums up what he calls "The American School of Psychiatry" in a discussion which has the same foundations as the psychobiological principles of Dr. Adolf Meyer. He feels, however, that Meyer's philosophy is too "common-sensed," and its terminology too involved, to appeal to the public imagination. This appeal to the public imagination seems to be Sadler's long suit, as exemplified in his former books, *The Quest for Happiness, The Physiology of Faith and Fear, The Mind at Mischief,* and so on. The present book suffers from this attempt to present a vast amount of material in semi-popularized fashion. It is thereby robbed of much of its scientific value. There are inadequacies and errors of termi-

nology, and apparently the accepted psychiatric nomenclature has been thought too colorless to use, even in a textbook on "the theory and practice of psychiatry." For example, in writing on mental hygiene, Sadler says:

> "We recognize that queer, nervous, maladjusted individuals—these so-called psychopathic personalities [*sic*]—are struggling with themselves and their environment much as an entrapped animal fights against something which has suddenly gripped him and holds him prisoner against his every effort to escape. Animals roaming about freely in the forest must be greatly puzzled as they observe the struggles of one of their fellows caught in a trap. This is precisely the situation of a human being who has become ensnared in a psychopathic muddle. These so-called queer individuals do not know what it is all about."

The catchy phrase-making in which the author indulges does much to harm the more valuable content of the book. In a discussion of neuroses as a class (Chapter 27) one finds such terms as "dodging reality," "neurologic disharmony," "earmarks of neuroticism," "thwarting of fear-flight," "tension controls," "tension accelerators," "tension reducers," "techniques of tension release," etc. In listing thirty-five categories of motivations in neurotic behavior, accurate terminology is sacrificed for euphemisms of Sadler's own invention—*i.e.*, "inadequacy concealment," "defeat dread," "regression retreat," etc. In citing illustrative cases, the author uses such terms as "all-around neurotic" and a "chronic neurotic ailer." Other instances appear in great numbers throughout the text, but especially in the religious discussion—*i.e.*, "the gospel of love," "horrific experiences," "spiritual shock absorbers," "dynamic convictions," "master motivation," "the Supreme Goal," "personality unification and salvation."

In the advice to general practitioners, there are many rather questionable references and the practitioner is admonished with such remarks as these: "The average general practitioner could double his practice within two or three years if he would begin intelligent ministrations of this class of sufferers [neurotics]. Many doctors could make a good living out of the neurotics he turns away from his office each year." In spite of this, there are many valuable suggestions for the practitioner who may wish to become a practical psychiatrist and personal counselor.

The chapters on psychotherapeutics contain many astounding statements which confuse the reader and are out of accord with an objective and truly psychiatric point of view. The following quotations are examples:

"They [neurotics] have grown up physically, but not emotionally. I often admonish hysterical adults, who are behaving like children, that the proper motor response to 'tipping the tear tank' would be getting down on the floor and crawling on hands and knees. We would like to help grown-up men and women to quit pouting, crying, and indulging in tantrums."

"It is a well known fact that sometimes, when you are unable to argue or reason people away from their worries, you can often literally ridicule them out of their fears. You can often help a woman to overcome her absurd fear of a tiny mouse by ridiculing her, after all efforts of reasoning have failed, and so, when logic is powerless to pry the patient out of the slough of despondency, do not forget to try a little wholesome ridicule."

"And so this struggle with one's nerves, after all, is determined by the strength of the moral nature. This whole nervous conflict is really an ethical one. We are all engaged in it. The normal, average person wages the battle without much ado, whereas the victim of weak nerves makes a great hullabaloo out of this normal fight of life and seeks to attract undue attention to himself by the much ado he makes over these commonplace struggles with his primitive nature—his biologic impulses and natural human emotions."

This is too often the lay attitude toward neurotic patients.

In the discussion of therapeutics, under the heading, *Liberation of the Soul,* there are some remarkable excursions into the spiritual realm. The discussion of will power and decision includes many statements with which psychiatrists will quarrel; for example:

"The will is the final arbiter of poise, it holds the balance of power in all mental operations. Its strength determines whether or not the body can be compelled to carry out the orders of the mind. . . . The will is the battleground of character formation, the will is to the mind what the sum total is to a column of figures. It is the master builder of character and the architect of eternal destiny. . . . The training of the will by self-denial and self-control is extremely important. . . . Here is the secret of the increasing prevalance of neurotic symptoms in recent years. It is due not so much to the strenuous life as to the lack of education of the will so that the power of free will can be used effectively. Lacking this, hysterical symptoms, unethical tendencies, and deficiency of self-control become easily manifest. . . . Now, at last, and through the power of definite decision, the human will becomes what God desired it should be, the majestic sovereign guide and ruler of the whole mental, moral, and physical domain or mental experience. But the will does not become such a power in one's life until the individual has learned how to decide things, until he has learned how to reach definite conclusions and then to throw himself wholeheartedly and unreservedly into the actual execution and carrying out of these conclusions. That is decision, and it never fails to spell deliverance for all those nervous sufferers, who, through patient perseverance, attain this practice."

Another startling statement is:

> "I regard prayer as a master mind cure, and personal religious experience as the highest and truest form of psychotherapy. Prayer and worship are also the safety valves of the soul."

The therapeutic aspects of the text are inadequate; the preaching and flights of allocutions which appear in the author's presentation of psychotherapy will certainly not be acceptable to psychiatrists in general. There are too many side issues. For example, the chapter on telepathy and mind-reading, reduced in the discussion to naught, surely has no place in a scientific book on the theory and practice of psychiatry. The scientific presentation is overwhelmed and overshadowed by the unscientific deluge. In general, there is an unsatisfactory attitude toward the victims of the neuroses, although unquestionably Dr. Sadler's own therapeutic technique is helpful in actual practice. The inspirational chapters fall quite short of any fundamental helpfulness, and the misstatements and inaccuracies will do much to harm the book's reliability as a text. Dr. Sadler seems to have compiled the purely psychiatric chapters in a vigorous and altogether praiseworthy frame of mind, but later, abandoning the more dogmatic psychiatric disciplines, he seems to have given full play to his bent for breezy popularizations and easy philosophies. He has not quite accomplished his aim, as expressed in the introduction, of delivering mental hygiene from its psychiatric mysticisms, its "confusion of tongues" and sectarian clamorings. In his chapters on psychotherapeutics he has rather contributed a great deal of confusion of tongues and a great deal of mysticism and confusing sectarian clamorings.

The book is a voluminous, detailed presentation which, up to the point of departure from scientific thinking, seems to be a thoroughly useful and commendable work. Its encyclopedic character will make it useful to the general practitioner and, as Sadler says, to non-psychiatric specialists.

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ADMINISTRATIVE PSYCHIATRY. By William A. Bryan, M.D. New York: W. W. Norton and Company, 1936. 349 p.

Books about hospital administration are not very many, and those about the administering of mental hospitals are indeed few; only once in two or three decades does something notable appear in this field. Periodical literature also is scantier than might be thought.

This book is an important work. In the first place it deals with

matters that have not been discussed in this systematic way before. In the second place, it is based on a considerable experience in fair hospitals, good hospitals, and very good ones. In the third place, it is formulated from the experiences gained during an outstanding career in this field. Among mental hospitals in which sound tradition has been coupled with broad vision and ingenious adaptation of experience and new ideas, the Worcester State Hospital has long stood high. Under Dr. Bryan's administration the reputation of this institution has been maintained and enhanced. From such a background may well come matters of value to all who study to make their hospitals more adequate to the needs of their patients.

Dr. Bryan's estimate of the importance of hospital activities appears early in the book: "the future of psychiatry and its influence on mental health will be built around the hospital." He remarks almost parenthetically that the ideas of to-day are largely not new. The first mental hospital about which we know was at Epidauros; it had a very fine theater and a stadium with room for 12,000 people; the modern mental hospital also has an assembly hall and recreational grounds. Hospital administration has been the most important of our therapeutic weapons, but for the past three decades, Dr. Bryan thinks, the mental hospital has been standing still. One may question whether such a feeling of insecurity as to how the outside physician may estimate our hospitals is entirely justified. One who visits many hospitals finds some that have gone backward, that are more crowded, that function less well. Many other hospitals have improved in the last thirty years.

The author discusses types of state organization and prefers that used by his own commonwealth, which indeed usually works very well. He advocates a special department under a hospital-trained and experienced psychiatrist, or in smaller states under a department of public welfare. He speaks a good word for the organization in New York State that was given up several years ago; instead of a board there is now a commissioner. This change was made not because the other system was working poorly, but because in a general reorganization of state departments, it was desired to establish a cabinet position at the head of every department. One may agree with Dr. Bryan that hospital men are sometimes more comfortable in a department of health than in a department of welfare. This has been the case in the city of Philadelphia and the province of Ontario, to cite instances.

Dr. Bryan also discusses the internal organization of the individual hospital under the labels of "monarchy," "dual control," and "participative democracy." He prefers the last; it is indeed a very fine

arrangement if the superintendent has the requisite energy to keep it active.

Functions of the hospital are forcefully described as the practice of psychiatry, medicine, and surgery, teaching, research, and prevention. Dr. Bryan proposes a mass attack by research, and offers an extensive, but largely theoretical program of prevention. He believes that the criteria of hospital efficiency are the number of patients returned to the community, the length of time they spend in hospital, and the length of time they remain in the community. One may differ strongly with his advocacy of decreasing the time spent by patients in hospital. It is only too probable that in scores of cases we push the patient out without giving him all the benefit that treatment might bestow. There was a time when some able surgeons advocated sending appendix cases home in five days, but the results were sometimes poor.

Mr. Bryan advocates family care for convalescents, and this no doubt is advantageous in some cases. In other instances it may be much better to have the patient directly under the care of his physician until he is well enough to go home.

There is a thorough consideration of the problems of building a staff and organizing the nursing activities. Dr. Bryan would have a superintendent surround himself with the ablest assistants and distribute responsibility among them. They should constitute a council, like the general staff of the army. There should be a manual of methods, graphic formulation of results, more nurses, scheduled qualifications for higher posts, a grading system, short hours, and arrangements for most employees to live in town.

The discussion of standards of care is most stimulating. Habit training, says Dr. Bryan, if enthusiastically followed by physicians and nurses, will sooner or later transform a hospital. It should cover personal habits, physical exercise, recreation, and social relations. He would have central bathing, chiropody, more barbers, smiling faces at dances, full-time chaplains. Finding psychiatrists forgetful of the physical body, he stresses the importance of the medical and surgical service, comprising a fifth of the hospital. A license to practice medicine, he reminds us, carries in the hospital the same responsibility that it does in the community.

Further on, the book deals with a miscellany of matters that are too often ill organized in hospitals. To mention a few, there are discussions of letters to patients, of a hospital publication, of bulletin boards, of the library, of group psychotherapy, of programs on the hospital radio, orientation trips for new patients, visits from interested groups, jobs. Dr. Bryan thoroughly believes in a teaching

hospital, and offers schedules of instruction for various groups. He would have employees of all grades spend two weeks in the wards. He joins those who would cease training undergraduate nurses except for a four-month affiliation course and he anticipates that the present supply of postgraduate students is stable. He finds research extremely difficult to manage—but extremely valuable. Public relations, social service, out-patient clinics are amply discussed.

Dr. Bryan asks state governments to rechart their course for the next hundred years and predicts hopefully that the parents of to-morrow will be more enlightened and better able to handle the problems of childhood. Did they think this in 1830?

The great values of this book lie in the record of what has already been done. Would that more of it were being done in all our mental hospitals! The author has made a distinct success of the type of organization and the distribution of functions that he outlines in this book. At the same time we must recognize that the hospital is the tool with which the psychiatrist works and that different men need different tools. One may regret, for example, that there is in this country no institution like Gutersloh, where the central idea of treatment is occupation, rather than nursing. Perhaps some of the arrangements described in this volume work better at Worcester than they might somewhere else.

With this slight concession to skeptical critics, the reviewer must again say that this presentation will be very helpful to hospital men throughout the country.

SAMUEL W. HAMILTON.

The National Committee for Mental Hygiene.

FAMILY CARE OF MENTAL PATIENTS. By Horatio M. Pollock. Utica, N. Y.: State Hospitals Press, 1936. 247 p.

As stated in the foreword, Dr. Pollock has here given us the first book in English on the subject of the family care of mental patients. For this we are all much indebted to him. The family care of patients with mental disease and mental deficiency has been carried on over a very long period of years, rather systematically in countries across the Atlantic and in a somewhat isolated and sporadic fashion in this country. All of these endeavors are in this book described and evaluated, thus giving us a very good historical background for our understanding of family care, as well as summing up the present situation in all areas, both foreign and local. We are given both the experience of the past and the practice of the present.

The reading matter is divided into two main parts—*Family Care*

in America and *Family Care in Europe*—and there are two appendices. Appendix A describes the family care of mental patients in various states of the Union, each section being written by the superintendent of a hospital who has had experience in this work. Appendix B deals with the forms for institution use in administering family care, and also contains an excellent bibliography and a useful index. The book has twenty-two illustrations, showing the types of home utilized for family care, as well as giving us pictures of community facilities for this work both abroad and at home.

Dr. Pollock has written two of the chapters in the section devoted to family care in America. The first, an introduction, describes the development of the work, the problems involved, and something of the cost, and includes an excellent statement as to the advantages to be derived from family care. The second is a chapter on the considerations relating to family care. This deals in some detail with the following points: (1) The system of family care to be adopted; (2) the selection of patients; (3) the selection of families; (4) the rates to be paid for the care of patients; (5) the supervision and treatment of patients in family care; and (6) the extent of use of family care. The other four chapters in this section deal, respectively, with family care of the insane in Massachusetts, experiences with family care at Newark State School, experiences with family care in psychiatric cases, and nursing homes for mental patients. Each of these chapters is written by an expert in the field.

In the second part, devoted to family care in Europe, Dr. Pollock wrote the chapters on family care in Germany, the family-care system of Scotland, family care in France, and family care in Switzerland and Hungary. Dr. Edgar A. Doll is the author of the chapter entitled, *The Lesson at Gheel,* which describes in some detail that well-known development in community care of the mentally ill and the mentally defective.

The reviewer can make very few unfavorable criticisms. It might be mentioned that here and there throughout the book one is left in some doubt as to whether the numbers given represent the number of patients placed in family care in a given year or the total number under care in that year. Again, there are certain paragraphs that one has to reread several times in order to grasp their exact meaning. These faults, however, are of such minor importance that reference to them seems almost carping.

We have long needed a book that would bring together the experiences of various countries in the family care of mental patients and elucidate their advantages and disadvantages. Dr. Pollock has met this need and has done so at a most opportune time. Many of the

leaders in psychiatry and in social welfare are of the opinion that we cannot go on indefinitely building institutions which all too often seem to invite the unloading of family problems upon the state, with the consequence of still further costs for construction and maintenance. In a number of states in this country the cost of the institutions for the mentally ill and the mentally defective is already assuming tremendous proportions. If we can meet this situation in a less costly, but still efficient manner, we shall have done a public service. Dr. Pollock shows that family care is less costly and in addition gives greater happiness to many patients, educates the public to a better understanding of the problems of mental disease, and tends to distribute public and private funds somewhat more widely and with more direct benefit to many individuals and communities.

Family Care of Mental Patients should be in the library of every mental hospital and every school for mental defectives, as well as in the hands of all social workers and others interested in social and economic welfare.

ARTHUR H. RUGGLES.

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HOME CARE OF THE MENTAL PATIENT. By Arie Querido, M.D. London: Oxford University Press, 1936. 100 p.

The purpose of this small volume, as stated by the author, "is to convey in simple language to the man in the street an understanding of the behavior and the ways of thinking of those who are ill in their minds." The greater part of the book is devoted to a discussion of the various types of mental disorder. The author adopts for his purpose a classification quite unorthodox. His principal groups of mental disorders are:

1. Diseases of the intellectual faculties. Under this heading he places feeblemindedness, senility, general paralysis, epilepsy, and chronic abuse of alcohol.

2. Diseases of the emotional life. Two classes are here distinguished: those with abnormal animation and those with abnormal dejection. These correspond fairly well with the manic and depressive types of manic-depressive psychoses.

3. Diseases of the structure of the personality. Two classes are described, the one with mild disturbances of the mental make-up, the other with disturbances of the mental personality accompanied by hallucinations and delusions. The descriptions correspond with the mental disorders usually designated as schizophrenia and paranoid conditions.

4. Disharmonic personalities. Under this heading are placed psychopathic personalities and neurotics.

In discussing these groups, the author recognizes the fact that disorders in each group differ in degree. Institutional care is clearly indicated for a large part of those seriously afflicted; home care of the better sort suffices for those with mild disorders unless special medical or psychiatric treatment is required. The book gives many helpful suggestions for the management of the latter group.

Any one charged with the care of mental patients in hospital or home will find many valuable ideas in this concise volume.

HORATIO M. POLLOCK.

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A PRACTICAL EXAMINATION OF PERSONALITY AND BEHAVIOR DISORDERS, ADULTS AND CHILDREN. By Kenneth E. Appel, M.D. and Edward A. Strecker, M.D. New York: The Macmillan Company, 1936. 219 p.

According to the authors, "the purpose of this manual is to guide the student in the technique of psychiatric examination." Some of the techniques described have been used by students at the School of Medicine at the University of Pennsylvania, while others have been found helpful in the authors' private practices. They wish the book to be considered as a laboratory manual. The introductory chapter on the art and practice of psychiatric examination presents all too briefly the authors' catholic point of view toward their field. The importance of rapport between psychiatrist and patient is stressed. The paucity of the literature on this subject is noted, and credit is given to the psychonalysts as the only physicians who have made an intensive study of this problem.

The authors point out, however, that analytic methods cannot be utilized in dealing with the majority of psychiatric patients. They then go on to outline in a direct and common-sense fashion their conception of the ideal psychiatric approach to patients. In this process they utilize many of the less controversial principles of psychoanalysis. The authors conclude that "it seems best, in dealing with patients, to adopt a questioning, interested, searching attitude with a desire to help rather than a suggestive advisory one . . . . and the evolving of this story [the patient's] is of prime value in psychiatric therapy."

In the ensuing chapters detailed outlines of the diagnostic groups, of the order for history-taking as obtained from family and patient, and of mental and personality examinations are given. These outlines conform quite closely to the formal outline used in most of the

American psychiatric clinics. Then the authors give detailed lists of questions that should be asked in specific situations. These lists tell the student just what to ask in all kinds of situation. The questions range from what to ask a patient when you want to find out about delusions, to what to ask a mother when you want to learn about her child's behavior. There are even separate chapters of questions on feeding difficulties, obedience, temper tantrums, enuresis (bed-wetting), jealousy, fears, lying, stealing, and masturbation.

The fundamental outlines for examination which the authors have given are clear and reasonably complete and will prove of value to students and teachers of psychiatry. The authors, however, have given too little space to the discussion of principles which they began so effectively in the introduction and have overweighted the book with extensive lists of stiffly formulated questions. The reviewer feels that these questions, if rigidly adhered to, would tend to defeat the authors' purposes of teaching students how to establish rapport with patients and how to write records that are not "lifeless."

The utility of this laboratory manual is seriously impaired by the lack of an index. There is a selected bibliography, but no reference is made to previous manuals of psychiatric examinations such as that of Kirby and Cheney.

EDWIN F. GILDEA.

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THE DEVELOPMENT OF MODERN MEDICINE; AN INTERPRETATION OF THE SOCIAL AND SCIENTIFIC FACTORS INVOLVED. By Richard H. Shryock. Philadelphia: University of Pennsylvania Press, 1936. 425 p.

This publication, consisting of twenty chapters, comprises 425 pages, with a detailed index. It purports to be an interpretation of the social and scientific factors instrumental in the development of modern medicine.

The author points out in his preface that his book is in no sense a study of the technical and chronological history of medicine, but is an effort to portray certain aspects of medical development against a background of intellectual and social history in general. As a general historian, he presents a study of the interrelationship of a vital group of arts and sciences so essential to cultural and social advances, of which the development of medicine has been a part.

The book begins with an exposition of the social and scientific factors instrumental in the development of medicine in the seventeenth century at a time when the first concerted efforts were made to establish a physical science. The partial failure in the applica-

tion of the physical sciences to medicine, however, during the early part of the eighteenth century engendered discouragement, disillusionment, and even condemnation of medical investigation and research. The complexity of biological phenomena and the limitations in methods of study were partly responsible for this attitude of discouragement, and medicine was referred to during that period as "the withered arm of science."

The author discusses social factors in medical lag after 1700. These deal with the forces of public opinion which forbade medical men to experiment with or to examine the material of most interest to them; with the relationship of the physician to his patient and the lack of opportunities for study and investigation as private practitioners; with the demand of public opinion that some logical form of complete treatment must be devised, thus pushing physicians into careless and hasty conclusions that were instrumental in the development of systems of medicine and systems of treatment that promised much to the public who wished to believe; with the advent of patent laws and patent remedies and the flourishing of quackery; with medical organizations that concerned themselves more with questions of precedence and privilege than with promoting scientific advance; with controversies on the private and public duties of physicians; with the conservatism of universities in medical teaching and the slow evolution of hospital facilities for entering that field; with rivalry between professional groups; with professional taboo on specialization; and with the humanitarian movement which acted as a stimulating influence upon medical science. It appears that during the eighteenth century most of the forces peculiar to medicine exerted a retarding rather than a stimulating influence upon it.

The latter part of the eighteenth century, however, witnessed some awakening of interest and a renewal of progress in medical science. The application of mathematics to biological science and the development of other sciences stimulated a current endorsement of science and inquiry, with a concurrent attitude of hope. Progress was made in anatomical and physiological research and in distinctions between the normal and the pathological. There was also a vindication of the empiricism of vaccination and inoculation that projected hygiene from an individual to a public plane.

That same period witnessed some contributions of physicians to the public welfare. Despite the fair economic opportunities of the time, public welfare and health were largely neglected. Some medical leadership did assert itself, but the inertia of the general public was offset only when catastrophic epidemics held sway. The author asserts that after the fifteenth century the number of publications

on hygiene and rules of daily living increased by geometric progression. The eighteenth-century list of publications was longer than those of the two preceding centures combined. These publications deal largely with the value for health of athletics and out-of-door games. The trend of public hygiene, however, showed a lag during the early part of the nineteenth century and the gains previously made awaited the correction of the evils of industrialism and new medical procedure. The problems of social reform, of improved living conditions, of sanitary reform, and of the abolition of poverty became intimately bound together and their solution was advocated by articulate, but isolated medical influence. Health programs, however, began to enter a definite phase of evolution in 1870, which marks the beginning of public hygiene. It was an age of romance, when philosophical speculation caught the fancy of an interested public.

Despite the romantic speculation of the first part of the nineteenth century, medicine of that period was not generally swayed by the fancy of the age. It is significant that there developed an intimate relationship between medicine and the development of the physical sciences. The outstanding men in physical science of the time were physicians, or at least had primary medical training. Mathematics and social sciences also made fundamental contribution.

Thus there began to emerge during the first half of the nineteenth century what may be called modern medicine, lagging behind the advances in other sciences, which fact may have stimulated medical advance from speculative to objective procedure. Old systems and doctrines were useless in practice and a new and inductive approach followed. Many of these early advances from a speculative to an objective procedure originated in France, its influence extending in Europe and America. The modern medicine of France largely evolved through hospitals as centers for investigation and training, whereas the Germans, profoundly influenced by studies in Paris, organized their university laboratories as research centers. Nothing quite like it had existed elsewhere and the value of laboratories to the systematic research of chemistry and medicine and with special reference to the university has become established.

During the early Victorian decades a signal distrust for the medical profession seemed to grow beyond ordinary bounds. At any rate it become more articulate during that period. The progress that medicine was making between the period of 1830 to 1850 was not sufficiently widespread to engender a feeling of public confidence. Quackery thrived and bitter controversies existed between various

systems or groups of the profession. With this was associated the growth of cults, so that public confidence in the profession was temporarily lost. Part of this public criticism was overdrawn, but there was evidence that the profession needed to reform within itself.

The emergence of modern medicine, with all its ramifications and triumphs, began to reap rewards during the last half of the nineteenth century. The most significant basis for further development, both in fields of public health and in the field of general medicine, was a clarification of the nature of diseases, many of which could be defined in terms of causes as well as in terms of symptoms and results. For the first time in history the medical sciences were coming to the aid of the healing art in a rational and systematic manner and the old hope that pure science would prove of practical aid to the sick was realized.

The evolution of preventive medicine was of equal significance. The author points out that there has been a lag in the advance against mental disease. In the latter part of the nineteenth and the early part of the present century, continuous efforts have been made, however, to apply the concepts and methods of contemporary medicine to this problem. These have met with only a certain measure of success and have been complicated by partial reversion to earlier methodologies in terms of systems, schools of thought, and controversies. An awakening of interest, however, in the relationship between the psyche and the soma, with reference to symptoms of illness, invalidism, and the economics of hospital and dispensary care, may be of great significance to modern medicine.

In the past several decades the economic rather than the scientific in modern medicine has become of greatest interest to the general public. Scientific progress since 1880 has inspired confidence in the medical profession, but this confidence has also created difficulties. Increases in the costs of medical care may have caused some difficulty, but it was a combination of these increases with a growing public demand for a wider application of medical services that has made the costs of medical care so acute during the present century. In former periods there was little concern on the part of the general public as to whether or not all members of a community received adequate medical services. With the increased confidence in medicine comes a belief that since people continue to suffer from diseases that can be prevented, cured, or ameliorated, medical science is not serving the people as it should. Thus the very progress in medicine that inspired confidence involves the profession in new difficulties in the practice of their art, with special reference to the economic

problems associated with illness among certain groups of the population.

The general theme of this interesting book—and like all books it is subject to errors of omission and commission—may be summarized as follows: The arts and sciences, the social, economic, industrial, and cultural factors in our civilization have been influential in shaping the trend, the outlook, and the development of modern medicine and its practice, and all of these may be expected eventually to influence the perspective of the future. W. L. TREADWAY.

United States Public Health Service.

CAN DELINQUENCY BE MEASURED? By Sophia Moses Robison. New York: Columbia University Press, 1936. 210 p.

PREDICTING CRIMINALITY; FORECASTING BEHAVIOR ON PAROLE. By Ferris F. Laune. Evanston, Illinois: Northwestern University, 1936. 163 p.

Here are two careful efforts at applying statistical techniques to the problems of misconduct. Both volumes fairly bristle with the latest improvements in mechanized warfare. Dr. Laune's effort is toward a more accurate and reliable prediction as to the success of parolees. Miss Robison's work, apparently based on the notion that you must set a thief to catch a thief, is a frank and quite exciting effort to show through tables and numbers the fallacies of the entire present statistical approach.

The Scot commented on the dominie's sermons: "Weel, aye canna ken; but aye can anyway admire."

Dr. Laune's array of coefficients of relation and other statistical wizardries is based upon certain assumptions that will be accepted with varying friendliness. 1. He points out that the formulæ developed by the Gluecks, Burgess, and others are based upon factors known before the individual enters prison. He assumes that we want to believe that prison life brings changes — for better or for worse. Therefore, prediction as to behavior on parole should be based on attitudes (and behavior) of prisoners if we are to justify in any way our prison costs. 2. He assumes the correctness of Dr. Kirchwey's statement that the opinion of fellow prisoners as to an inmate's parolability is the most accurate measure we have. 3. Lacking the time to discover whether predictions made in prison are corroborated on actual parole, he makes the statistically valid assumption that close agreement (by several observers) in prediction is equal to actual performance of the behavior predicted. 4. Lacking the facilities for an objective and "honest" appraisal of parolability by fellow prisoners, he assumes that attitudes can be determined by truthful answers to a

large number of apparently innocuous questions as to behavior. Seventeen hundred questions (dealing with objective criteria for certain attitudes) were submitted to fairly large groups and the resulting replies squeezed dry of every possible correlation or other statistical significance. Of these, 161 questions were chosen as of key significance. If you accept the four basic assumptions, the prisoner's yes or no answers to these questions will tell you his percentage chance of success on immediate parole.

It is odd to find the psychoanalysts and now the statistically minded sociologists equally showing this brave faith in symbols that allows them to predict years of behavior on the basis of answers to "Are you considered strong-minded by others?" "Did you buy only what clothes were absolutely necessary?" "Are you afraid of snakes?" and so forth.

Miss Robison's book has been given unfortunate publicity by its publishers. It doesn't even pretend to consider several matters which advance notices indicated that it would settle for good and all. It raises the question as to whether there is such a valid thing as a delinquency rate. Methodically, and with good statistical technique, it proceeds to show that there probably is no such reality and that there certainly is no present method of finding it. Using the records of court and non-court agencies in New York City, it shows that no numerical data available to-day can be thought of as presenting an adequate picture of the problem of misconduct, or as the basis of setting up a "rate" that would allow the comparison of the delinquency in one area with that in another or would allow of such a picture of trends as could be used in predicting the size of future problems. What Miss Robison comes to through her tables is really the view that has often been expressed (perhaps best by E. Sapir) that you can't add Catholics, or Austrians, or people-who-live-on-the-third-floor, or residents of the Fourth Ward. Apparently these attributes attain their meaning for each individual only on the basis of their relationship to the other attributes which that individual happens to have. If you enjoy seeing the statistician confounded by his own tricks, the book is good reading and is recommended. With all its numbers, it has a certain inexorable sort of realism that is lacking in Dr. Laune's work.

Miss Robison's war to end wars has apparently consumed a great deal of time and energy. If it succeeds in its purpose, one perhaps can forgive the time that so understanding a worker has spent on such unrealistic aspects of the problem of behavior.

JAMES S. PLANT.

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THE INTELLECTUAL FUNCTIONS OF THE FRONTAL LOBES: A STUDY BASED UPON OBSERVATION OF A MAN AFTER PARTIAL BILATERAL LOBECTOMY. By Richard M. Brickner, M.D. New York: The Macmillan Company, 1936. 354 p.

Dr. Brickner's book presents one of the most detailed and fascinating studies of a psychobiological experiment that the reviewer has ever encountered. It would be folly, in a review of the work, to attempt a recapitulation of his study and analysis of the patient, as a careful and critical reading of the entire text is essential to a grasp of the soundness of his argument.

In brief, he presents the history of an individual who in the late summer of 1930 underwent the operative removal of a large portion of both frontal lobes in the eradication of a brain tumor. One hundred and sixteen grams, or about 9 per cent by weight of the total amount of brain tissue, was removed. The patient came under the author's observation later, and since November, 1931, efforts have been made to reëducate him and detailed notes have been kept of physical, neurological, psychological, and other tests, together with full descriptions of his behavior. The facts thus collected are compared with those relating to the patient's behavior prior to his illness and operation as revealed by a detailed history collected from a variety of sources, including several members of his own family and former friends. The result is that the reader gets a vivid impression of certain fundamental changes in the personality.

The author then compares his findings with those of others who have studied similar patients and arrives at the conclusion that the primary function of the frontal lobes is concerned with complex syntheses. The disturbance of this function he finds no greater when abstract thinking is principally involved. He looks upon it as a quantitative change, and the behavior changes that are frequently described as associated with the loss of the frontal lobes he looks upon as secondary or tertiary derivatives. Thus the general impairment of restraint, judgment, initiative, *Witzelsucht*, and many of the other phenomena commonly described he believes are to be attributed to this fundamental impairment of the intellectual function—the difficulty in complex syntheses.

The whole study is brought into line with the more recent advances in experimental work on animals and supports what seems at present to be the most useful way of looking at brain functioning. The quotations and extracts from the literature are ample and accurate and the bibliography is excellent.

It is the belief of the reviewer that the author has made a distinct

and valuable contribution to the study of human behavior, and the book is one that those working in this field can ill afford to pass by.

LAWRENCE F. WOOLLEY.

The Sheppard and Enoch Pratt Hospital, Towson, Md.

JUVENILE PARESIS. By William C. Menninger, M.D. Baltimore: The Williams and Wilkins Company, 1936. 199 p.

The author of this monograph has brought together in masterly and scholarly fashion all of the known facts and theories regarding juvenile paresis. The discussion of the etiology and of the clinical and laboratory findings is thorough, including an analysis of all reported cases, as well as a detailed report on the author's own material. The discussion of the development of juvenile paresis and its clinical course is so complete and so well illustrated with case material that this monograph will undoubtedly attain rank among the classics in this field.

Among numerous cases cited, of special interest is one of the rare instances in which both parents suffered from general paresis and syphilis. Significant also is the discussion of the relationship between juvenile paresis and feeblemindedness, in which it is pointed out that in many instances the mental deficiency is the result of the brain syphilis and is to be considered a part of the disease.

The discussion of the psychological mechanisms involved is of some interest in that they have previously received too little emphasis in the literature. The treatment is thoroughly discussed, and both gross and microscopic pathology are described and illustrated with beautiful plates. The bibliography is unusually complete, listing 530 references.

In short, this work brings up to date in complete summary our present knowledge of juvenile paresis. It will be invaluable to any one working in this field.

LAWRENCE F. WOOLLEY.

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THE DIAGNOSIS AND TREATMENT OF BEHAVIOR PROBLEM CHILDREN. By Harry J. Baker and Virginia Traphagen. New York: The Macmillan Company, 1936. 393 p.

This book presents a method for the analysis of behavior problems in children, leading to specific numerical scores. The method is presented together with a case-record form, in which the data can be summarized under 66 diagnostic items, covering (1) health and physical factors, (2) personal habits and recreational factors, (3) person-

ality and social factors, (4) parental and physical factors in the home, and (5) home atmosphere and school factors.

The gathering of the data about the child is reported to require a minimum of two hours. Explicit directions as to the material to be covered under each section are given by the authors. Each trait or factor is rated according to a five-point scale. The score is then weighed in a very simple fashion and the total score indicates the severity of the problem. The scale is, of course, a means of evaluating and not a means of treating problem children.

Multiplication of records of this type should yield useful statistical material on the etiology of or associated factors in personality and behavior disorders in childhood. The device should also prove useful in selecting, from among a large number of children, all of whom show problems, those most acutely in need of intensive service.

In the preface to the book, the authors state that intellectual differences have been successfully measured by mental tests and that the emotional field should not prove too difficult. There follows a statement that the measurement of feelings is not a simple and mechanized process. Later one learns that specific numerical scores remove diagnosis and treatment from the field of subjective opinion, and then one is told that the subjective element remains, but to a less degree. Twenty-five psychologists and social workers decided the location of the descriptions or numerical scores in the five categories.

It is obvious that consultation should be asked from the medical profession before another edition of the book is published, since a great deal of the material is from the fields of pediatrics, psychiatry, and psychoanalysis. Diagnosis and treatment in these fields is freely discussed, but for the most part badly handled. To quote a few instances, we find (p. 126): "It is important to remember that bodily conditions alone do not cause behavior problems, except possibly in epilepsy, encephalitis, and insanities"; (p. 119) "The system of a mother who is unhappy and nervous or sickly during her pregnancy contains poisons which may affect the system of the embryo"; (p. 114) "Bad teeth and tonsils may generate poisons which inflame the eyes, making them muddy and painful"; (p. 125–6) "In extreme cases imaginary illnesses are symptoms of hysteria or other forms of insanity"; (p. 201) "When teeth occur in dreams, X-rays should be taken for possible pus pockets." Certain terms used in the book—"mean disposition," "mean behavior," "meanness," "dirty mind," and so forth—may serve some useful purpose, but it would seem that better expressions might be found.

In conclusion, the authors state, among other things (p. 387) that "the Detroit scale of behavior factors" offers possibilities as an

aid to prognosis and to mental measurement, "which has been expected in some mysterious way to solve problems of delinquency." The scale "is only a beginning for a more comprehensive and intelligent approach to the problems of maladjustment of delinquency. . . . By the use of this scale the real work of behavior diagnosis and treatment is not ended, but just begun."

The reviewer is in agreement with that part of the editor's introduction in which she states that the volume presents an "instrument for appraising the problems and difficulties of children," and that "any child who is in need of help can be viewed against this remarkably complete analysis sheet of a human life."

RALPH P. TRUITT.

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NOTES AND COMMENTS

Compiled by
PAUL O. KOMORA
The National Committee for Mental Hygiene

THE SEVENTIETH BIRTHDAY OF ADOLF MEYER

"A remarkable tribute!" This characterization of the event by an observer sums up, in a phrase, our impressions of the twofold celebration held in Baltimore on April 16 and 17 to mark the seventieth birthday of Dr. Adolf Meyer and the beginning of his twenty-fifth year as director of the Henry Phipps Psychiatric Clinic. Remarkable it was for the large and distinguished assemblage of professional and lay people who came from far and near to do him honor, for the unanimous recognition of his supreme position in mental medicine, for the personal esteem and affection shown for him as man and as physician, and for the varied and manifold evidences of this high regard manifested on the occasion.

For the many former students of Dr. Meyer who were there, the gathering took on the aspect of an alumni reunion, augmented by the presence of many of the leaders of American psychiatry, a veritable *Who's Who* of the profession. How fruitful and extensive his influence as a teacher has been was indicated by a world map showing the distribution of his pupils: 83 teachers and 58 practitioners in North America, and 17 teachers and 10 practitioners in the eastern hemisphere. A special number of the *Archives of Neurology and Psychiatry,* containing this map, was presented to him by Dr. Stanley Cobb, of Harvard Medical School, on behalf of the American Medical Association, in "appreciation of his services to psychiatry and to American medicine." This issue was made up entirely of contributions by pupils of Dr. Meyer.

Speaking of Dr. Meyer's work as a teacher, Dr. C. Macfie Campbell said it was not without significance "that during the World War, Dr. Salmon observed that New York State psychiatrists could easily be identified at army headquarters by the character of their reports, as men whose training and habits of work had been shaped by Dr. Meyer."

A substantial part of the exercises consisted of a scientific program specially prepared for the occasion: an afternoon session, on the first day, at which eight papers were presented, all by former students of Dr. Meyer's; and a morning session on the following day at which

the Phipps staff presented a cross-section picture of the clinic's activities in 1937. Both sessions were held in Hurd Memorial Hall and presided over by Dr. Meyer. The high mark of the celebration was a banquet at the Belvedere Hotel attended by more than 400 guests, and presided over by Dr. Campbell, a former associate of Dr. Meyer's at Phipps.

Many and varied were the honors showered upon Dr. Meyer at this function: messages of congratulation sent by eminent scientists from this country and abroad, inspiring addresses by colleagues associated with one phase or another of Dr. Meyer's professional career, and other more tangible tributes from various scientific bodies. The New York Psychoanalytic Society and Institute elected him to honorary membership; The National Committee for Mental Hygiene elected him as its honorary president; and his co-workers presented him with a complete bibliography of his writings and their own, together with a surprise gift in the form of a collection of 178 photographs of present and former members of the Phipps house staff. Dr. Esther Loring Richards revealed the fact that the pictures were the product of a house "conspiracy" and plan of strategy to induce Dr. Meyer to sit for a portrait, which he had previously declined to do, and the hope was expressed that he would now consent, "in exchange for this gift."

With characteristic wit and humor, Dr. Campbell turned the proceedings into a "case conference," with Dr. Meyer as the "patient" and himself as "clinical director." Responding in kind, Dr. Meyer complimented his hosts on the success of the "conference." "It was not," he said, "a condition of pure embarrassment," as Dr. Campbell had conducted it.

Adopting the genetic approach, the speakers traced Dr. Meyer's life history from his earliest days as docent in neurology at the University of Chicago and pathologist to the Illinois State Hospital at Kankakee, shortly after the completion of his medical studies at the University of Zurich and other European centers and his migration to the United States in 1892. Dr. Ludvig Hektoen, of Chicago, recalled the pioneer efforts of Dr. Meyer in the "horse and buggy" period of American psychiatry and his fundamental contributions to clinical and research advancement, in spite of the limited opportunities available to him at that time. "He had started from scratch, under difficult conditions," Dr. Hektoen said, "but through a complete and courageous devotion to high ideals, he accomplished much more than was understood at that time in developing practical and scientific work in his field."

Dr. Downey Harris, of St. Louis, discussed his associations with

Dr. Meyer during the period of his work at Worcester, Massachusetts, where he served as clinical director of the state hospital and taught psychiatry to the graduate students of Clark University, where he laid the foundations of his brilliant career, and, through eight years of tireless labor, forged the instruments of research and study that were to exert such a profound influence on the course of psychiatry in this country. It was here, as Dr. Campbell has pointed out elsewhere,[1] that Dr. Meyer "began to work out, on the basis of his own clinical material and with a comprehensive point of view which did justice to all the facts, an orderly system in which he could group the real material of the psychiatrist's experience, with its varied aspects."

Professor Robert S. Woodworth, of Columbia University, spoke of Dr. Meyer's work as director of the Pathological (Psychiatric) Institute of the New York State Hospitals and professor of psychiatry at Cornell University Medical College (1902-1910), pointing to his anatomical researches of that time as "an achievement of considerable merit in the history of that science." In this connection it was brought out by Dr. Louis Hausman, at one of the scientific sessions, that of 155 papers written by Dr. Meyer since 1891, 20 per cent were devoted to anatomical and neurological problems. This, said Dr. Hausman, serves to remind us of Dr. Meyer's many interests. Although his fame in psychiatry is world-wide, his accomplishments in neuroanatomy and neurology are of no mean significance.

Praising Dr. Meyer's contributions toward the development of a closer relationship between psychiatry and psychology, Dr. Woodworth said: "The psychologists have to thank Dr. Meyer, for he was one of the first who were willing to extend the facilities of the psychiatric clinic to the psychologist for the purpose of increasing their knowledge of psychology—that is, for the light which the abnormal throws on the normal." Dr. Woodworth also paid tribute to Dr. Meyer's broad interest in the social aspects of his field, and extended the greetings of the Social Science Research Council, of which Dr. Meyer was "an active and very much respected member for a number of years."

The Ward's Island period of Dr. Meyer's career saw many significant developments in clinical psychiatry, state-hospital organization, staff training, and laboratory work, among them a thoroughgoing revision of case-history methods. He outlined a guide for history-taking which became the standard not only in the New York state hospitals, but throughout the country, and contained, in germ, the revolutionary ideas that developed into the comprehensive system of

[1] *Archives of Neurology and Psychiatry*, April, 1937.

study so widely used to-day. Dr. Meyer's "psychobiology" is the dominant orientation in present-day psychiatric study and teaching in this country, and has exerted a marked influence on psychiatric thought and practice the world over.

Evidence of this was furnished by Dr. David K. Henderson, Director of the Royal Edinburgh Hospital, who brought the greetings of the Scottish Division of the Royal Medico-Psychological Association. Dr. Henderson said: "Meyer's influence in producing a more vital and stimulating outlook in psychiatric work in Scotland is perfectly astonishing." Acknowledging the potency of Dr. Meyer's theoretical conceptions and his "ability to visualize," yet, Dr. Henderson pointed out, "he has never let it interfere with his practical judgment and his practical outlook in regard to the care and treatment of his patients. We have many research workers to whom patients mean nothing, many clinicians who can't see beyond the bedside, but we have, through the influence of Dr. Meyer, this correlation between theoretic conceptions and their practical application." Dr. Meyer's interest in human beings and in dealing with their actual difficulties carried him beyond theoretic discussions, and, as Dr. Campbell put it, led him to get a more complete and living picture of the everyday life of his patients in their natural environment and to help the patient and his family to realize that the physician is not engaging in a merely technical procedure, but trying to offer real help in practical difficulties.

A side light on this aspect of Dr. Meyer's methods was brought out by several speakers in their references to the part played by Mrs. Meyer in shaping the career of her distinguished husband. Her interest in his patients, many of whom she visited and helped in their homes, foreshadowed the ministrations of the psychiatric social worker and the modern system of after-care whose development Dr. Meyer encouraged from the beginning. Dr. Meyer's respect for *facts;* his insistence on accurate, precise, and methodical history-taking, with scrupulous regard to the facts; and his realistic adherence to the concrete, as against the abstract, with due regard to the complexity of human nature, led him to subordinate the nosologic approach to that painstaking, detailed observation and study of the whole situation which is at the heart and center of his "psychobiological" formulation.

Dr. Meyer's achievement in integrating the work of the Phipps Clinic with Johns Hopkins Hospital furnished the theme of the address by Dr. Winford H. Smith, superintendent of the hospital. Harking back to the opening of the clinic twenty-four years ago, Dr. Smith recalled the remarks of Dr. Osler at the dedication exercises,

and said that the sentiment on that historic occasion "was that the opening of the Phipps Clinic marked a new era in medicine." "It seems to me," Dr. Smith went on, "that this event is also a notable occasion. Had the venture started so auspiciously twenty-four years ago not been a success, there would be little point in these exercises. We are, therefore, celebrating a notable achievement in the field of psychiatry and by so doing we are paying the highest possible tribute to the one man more responsible than all others for that accomplishment. Dr. Meyer and his associates have justified the high hopes and the prophecies of those who participated in the inauguration of this movement and of those who selected him for the task. Dr. Osler said at the opening exercises: 'One may ask legitimately how such an institute as this may be helpful in studying the lapses and freaks of the human mind. I cannot give the answer; it is not in the book I learned from. I could tell you in internal medicine, but the scientific unit designed for the study as well as for the cure of mental aberrations is a novelty in a general hospital.' In the brief life span of this clinic, it has ceased to be a novelty."

In this connection, Dr. Stewart Paton singled out as one of Dr. Meyer's important contributions his strictures on the "vices of departmentalism." Dr. Paton was introduced as an "unofficial ambassador between medicine and the community, a sort of Mr. House in the psychiatric world," who had prepared the ground in Baltimore for the advent of Dr. Meyer and the Phipps Clinic. "To-day," Dr. Paton said, "we are suffering from the vice of excessive specialization. People don't know how to connect detached bodies and wandering minds. The first thing you have to do is to take account of our total activities; in other words, we have to give up being specialists. There has been a great deal of talk about disease, but the greatest trouble is what is happening in the way of dis-ease—that is, taking the total activities into consideration." One of the great things that Dr. Meyer has done, Dr. Paton added, "has been to teach us how to take an intelligent interest in ordinary events of daily life. His experience and training to make haste slowly has also been of great advantage. He always had time for his associates and pupils and patients."

This interest in the work and life of others was exemplified in his notable service to the mental-hygiene movement, which Clifford Beers, founder of the movement, described in terms of his collaboration with Dr. Meyer in the early days of organization. To Dr. Meyer he gave credit for his initial success in launching the movement on a sound and scientific basis. Their collaboration began, said Mr. Beers, when he submitted the manuscript of his autobiography, ***A Mind That***

Found Itself, and received from Dr. Meyer the constructive criticism and wise guidance that contributed so heavily to the successful publication and favorable reception of his story. "He did a very courageous thing and, as events proved, a wise one, when he supported me," Mr. Beers continued. "Dr. Meyer was the one man whose standards were of the highest, who was the outstanding leader of psychiatry in this country. If I could win him across, every one else would follow. Later he named the movement and helped formulate a plan and policy. Then I asked him for a letter 'to whom it may concern,' and I used that in securing funds for the work."

The meeting reached its climax with a standing ovation to Dr. Meyer as he arose to speak, visibly moved by the encomiums and honors heaped on him through the day's proceedings, beginning with the enthusiastic demonstration which greeted him on his first appearance at the scientific sessions in Hurd Memorial Hall. Dr. Campbell presented him as a great humanist, as well as scientist and scholar, who had built up the structure of modern psychiatry, which he compared with the symmetry and character and social value of the great cathedrals. Again he likened psychiatry to a living organism in which Dr. Meyer functioned as the "pituitary gland," furnishing the hormones that made it grow and develop into the vital force it is to-day.

Quickly establishing his customary rapport, Dr. Meyer held the attention of his hearers through thirty minutes of intimate comment on the internal workings of the institution he founded and the inner meaning and significance of the developments during the past twenty-four years. In his analysis of the life history of the clinic, made with characteristic penetration and insight into "all the facts," he expressed "intense gratification" at the spirit of understanding and coöperation that permeated the organization at all times, and gave high praise to his co-workers and their "spirit of adventure and investigation." "It has done a great deal for me and my equanimity," said Dr. Meyer, "to have heard, throughout, some intimation of the spirit in which the life in our clinic has shaped itself, the spirit of 'give and take,' of working together, of doing each what he can toward stimulating and understanding the others." In the course of his response, he paid a glowing tribute to Henry Phipps—to the "creative urge of a rare philanthropist, who made the clinic possible and who saw the importance of amelioration as well as the solution of the problem."

Dr. Meyer enlarged upon this topic in an illuminating address at the conclusion of the program at the second scientific session on the following day, in which he traced the evolution of the clinic from its

beginnings to the present day, and projected some of the developments, and their underlying principles, as he saw them in the future. In this paper, which reflected his philosophy of psychiatry, he defined psychiatry fundamentally as "the development of planned work with mental diseases." The progress of medicine during the nineteenth century, he said, had been, in general, along the line of structural pathology and an experimental method, in which psychology and general behavior problems were ignored and the "fundamental sciences," such as physics and chemistry, played the major part; whereas with the transition into the present century, "it became clearer and clearer that the science, fundamentally, in the field of psychiatry is the total function of man, man's function as a person, which was not included in the concept of science as understood by the pathologist in this country even to-day." The German conception of the science of man, for example, he pointed out, is oriented around physiology and chemistry, and as a result of the schism between "physical" and "mental," the study of man *as man* has been left too largely with the philosopher on the one hand and the physiologist on the other.

"I tried to bridge over the gap," Dr. Meyer said, "by speaking of having to cultivate the 'missing chapter' of physiology, while really depending on the appeal to the broader science of biology; which expresses itself in what I consider the fundamental training in this whole chapter—namely, psychology on a biological basis; therefore called psychobiology. The functions of the human being, the functions of the person in the service of life, must be studied not as a sort of parallel in the phenomenological sphere, but as a functioning of the person with the same necessity of dynamic laws that we apply to any kind of nature and that we apply to special organs in physiology and just as seriously to our life as a total person, to the study of man in health and disease."

Educating for Mental Health

The ideal of "a sound mind in a sound body" has long been implicit in the educational systems of our western civilization. For a generation or more our schools have recognized their responsibilities for the bodily health of their charges by providing programs of physical training and hygiene, and, in varying degrees, medical, nursing, and dental services. Only in recent years have they begun to give attention to the subject of mental health and to recognize its importance not only for its sake, but as a basic factor in the achievement of their essential educational objectives.

The significant extent to which mental-hygiene concepts are filtering into educational thought and practice in this country is evident

from the discussions which took place at three "regional" conferences held during the month of April for the purpose of promoting coöperative action between mental-health workers and the schools. These conferences were conducted in Wilmington, Detroit, and Philadelphia, under the joint auspices of The National Committee for Mental Hygiene and the three local mental-hygiene organizations—namely, the Delaware Society for Mental Hygiene, the Michigan Society for Mental Hygiene, and the Mental Hygiene Committee of the Public Charities Association of Pennsylvania. In each city hundreds of teachers attended two-day sessions devoted to such topics as the mental-hygiene implications of non-attendance, the mental health of the teacher, mental-health problems of the gifted child, the relationship between mental health and cultural aims in education, etc. Nationally known psychiatrists and psychologists of wide experience in the educational field addressed the sessions, together with state and local superintendents of schools and educational authorities in various fields.

The conferences were in the nature of educational "clinics," in which the ills of our school systems were diagnosed, problems and difficulties analyzed, educational philosophies critically evaluated, and mental-health issues discussed pro and con. A wide selection of speakers, representing varied interests and points of view, and making for free and broad discussion, brought out marked divergences of opinion on specific points, but also a striking agreement as to the community of aims and interests between mental hygiene and education. From these conferences the mental-hygienist got a valuable cross section of present-day educational opinion on mental-health doctrine; and the educator new insights into the mental-health implications of existing school practices.

Only the high lights of the discussions can be given in this account, which must necessarily forego anything like an adequate reporting of the many topics and views presented at the three meetings. It is planned to publish a number of the papers in full in later issues of this journal. Here we attempt only a sketchy picture of the ground covered under the main headings, quoting chiefly from the following speakers: Dr. Bruce Robinson, Director, Department of Child Guidance, Newark (N. J.) Public Schools; M. Ernest Townsend, Ph.D., President, State Teachers Training College, Newark; Dr. Clarence M. Hincks, General Director, The National Committee for Mental Hygiene; Dr. E. Edward Harkavy, formerly psychiatrist at Bureau of Attendance, Board of Education, New York City; Dr. Ira S. Wile, former Commissioner of Education, New York City; Walter Hullihen, Ph.D., President, University of Delaware; Burton P. Fowler, Head

Master, Tower Hill School, Wilmington; Carleton Washburne, Ph.D., Superintendent of Schools, Winnetka, Ill.; Dr. James S. Plant, Director Essex County Juvenile Clinic, Newark; Harvey Zorbaugh, Ph.D., New York University.

Broadly speaking, the appraisal of present conditions in the school system fell under two main aspects—(1) the mental-health implications of teaching methods, curricular and administrative practices, and (2) the influence of the teacher herself on the mental health of school children. It has long been felt that the school must be the focal point in the long-range program of the mental-hygiene movement and that the prevention of mental and nervous disabilities can best be achieved through prophylactic work with children during the school period. Hence the importance of measures dealing with those factors in the school situation that make for mental health or ill health.

The mental health of the teacher herself was regarded as pivotal, and was discussed from two angles: by a teacher trainer, and by a child-guidance psychiatrist. Dr. Robinson, for example, said that too little attention has been given in the past to the selection of teachers on the basis of personality, "which is our best symptom of mental health"; that the selecting authorities seldom inquire into the mental health of the prospective teacher; and that no ordinary interview programs and no devisable system of examination can develop in the selecting agent the necessary understanding of the applicant's personality and therefore mental health. "No such selective procedure can hope to succeed," he said, "unless it is aided by adequate personality study made over a period of years by the trained personnel of the teachers college."

Dr. Robinson held that most of the emotional difficulty noted later among teachers should have been recognized during the probationary period, if a proper study of the teacher had been made during that time; and that the principals and supervisors would need to be trained in the study of teacher personality to do this during the time of probation. "Only a little study of the problem of teacher mental health," he continued, "will show that there are certain behavior patterns that are associated with mental health and that are absent in those individuals who develop emotional difficulties during their professional service." He pointed out, for example, that a teacher or any adult needs wide and active interests in order to maintain mental health. "It is unlikely," he said, "that a person whose school interests have been wholly academic, who has been a 'bookworm,' will acquire suddenly the wide and active interests necessary for mental health."

Emotional maturity, said Dr. Robinson, is a further essential to healthy living and the gaining of satisfaction from efficient professional service. "We know that few people suddenly become 'grown up,' and therefore we need to know the developmental history of the teacher, so that we can judge his adult maturity through a knowledge of his having acted his age at the different levels of development. If the family has always closely supervised the individual and made him dependent upon his parents for guidance and upon the home for security, then we cannot regard him as a good risk in education because of his immaturity." On the other hand, unless the schools are made healthful places for teachers to work in, "it is of little use for us to select as teachers individuals of superior personality, and we must study the school environment so that we may remove unnecessary interferences with the maintenance of mental health."

It is also important, Dr. Robinson said, to have emotionally mature supervisors who do not allow an excessive number of rules and regulations to interfere with satisfying, responsible, and independent work on the part of the teachers. "It is a symptom of emotional immaturity in an executive to gain satisfaction from the imposing of rules and regulations, many of which should be abandoned as unnecessary irritations and a denial of teacher maturity." The primary interest in education should be in the personality development of children, he concluded. "Children cannot receive through school experience the help they need in desirable personality development unless they are in contact with teachers who have been selected because of good personality and who are working in a school environment and living an out-of-school life that stimulates the maintenance of mental health."

Asserting that an undue proportion of teachers are so maladjusted, or mentally sick, as to "constitute a present menace to the process of education," Dr. Townsend cited some of the factors that contribute to such maladjustment. Among them he mentioned burdensome paper work which keeps teachers up to all hours of the night. "An occasional fling of this sort is unavoidable," he said, "but the teacher who would be mentally healthy will come to realize that a tired, irritable teacher is a menace." He also criticized system-minded administrators who put teachers in subservient states of mind. Instead, "we should put the teacher in the center of gravity and relegate administration to its proper sphere of human or personnel management, as industry is doing." Incidentally, he expressed the opinion that rules against the marriage of teachers are not only keeping many of the better type of young women out of the teaching profession, but are also contributing toward the maladjustment of those in the school system.

"Education," Dr. Townsend said, "is concerned primarily with the development of a generation of emotionally sound, mentally mature, morally responsible persons. . . . Teachers are the great buffers between unregulated tendency toward disintegration and the more deep-seated tendency toward personality growth. Our modern civilization has certain typical hazards which must be guarded against. Against these hazards we must place a corps of teachers whose fearlessness, whose emotional maturity, whose honest love for humankind, whose keenness of insight will counteract and overbalance these hazards." Since we cannot select the children, we must select the teachers, he concluded. "We can learn to know what kind of people those who want to come into the profession have been. We can select for intellectual ability, yes. But, far more important, we can select and help to guarantee persons for the profession who know how to keep well, who have a rich pattern of interests, who are positive and not negative personalities, who understand what culture is all about, and who are capable of becoming emotionally mature."

Speaking along the same lines, Dr. Hincks said that in most cities teachers still qualify for their positions mainly through academic effort, and that little or nothing is done to determine whether or not the candidate will have a good or a bad influence upon the emotional lives of her pupils. "Yet every one who can remember back to childhood recalls vividly the 'good' teachers and the 'bad' teachers—those whose sympathetic understanding made school interesting, and those whose irritability and apparent lack of understanding made us detest school and think of playing hookey."

It is because children "hate school" that there is a non-attendance problem, according to Dr. Harkavy. This non-attendance, he said, grows out of the child's desire to be somewhere else than in school. "School to that child is the exemplification of everything that he does not like. It is one vast chore." If teaching could be restricted to the furnishing of young minds with the material of the curriculum, he continued, all would be well. "But whether we like it or not, the business of teaching involves a host of human relationships. Children are rewarded and punished; they are well-behaved and eager, or they are troublesome and dull. The teacher, in her turn, is invigorated and happy, or she is angry, hopeless, and weary." In the latter classroom, where teacher and children are obviously hating the whole procedure, a simple fact is noticeable, he said. "The teacher is trying to coerce her children into a frame of conduct that will enable her to teach, and the children are resisting. I want to point out that a young child who is exposed to eight years and more of such systematized coercion is very likely to give in. But the price at which the

teacher's victory is bought is a dear one. If a child cannot defy you successfully in the classroom, he will invent a world in which he overcomes you. Any child can make a life that you can't take from him. And the device that the child found useful in the classroom may now be used in the world at large. If things go wrong in the world around him, if the child feels that he may fail, he retreats into the safety of the self-invented world that we have forced him to create. This is the breeding ground for most of the nervous diseases of our civilization. The teacher who conducts a happy classroom is not only a good teacher; she is performing a great service of prevention."

Discussing the relationship between mental health and cultural aims in education, Dr. Wile declared that our mental hospitals "are overcharged with responsibility for the very serious and almost incurable mental disorders that have developed among the adolescent and mature population whose cultural aims have been emphasized while their mental health has received inadequate attention." If cultural aims are advanced at the sacrifice of mental health, he said, then education is itself a mental hazard. Culture in itself may help to establish character traits, but requires adaptation to the capacity and needs of students, and those who transmit culture may be of more importance than the data they transmit. "Impact of personalities tests emotional stability, which is the foundation of mental health." Citing those who emphasize knowledge as the aim of higher education, on the one hand, and those who stress the significance of education in terms of personality development, on the other, Dr. Wile held that "the combination of these two aims constitutes the rational middle course." Personality is influenced by, and subject to, the impact of knowledge, he said, while knowledge is sought by individuals in terms of their personalities.

Looking at culture from another angle, Dr. Hullihen said that Americans need feel no fear of too great devotion to any standard that would withdraw them harmfully from the busy interests of the marketplace, the shop, the factory, and the office, in which we are "preëminent." "The argument for culture," he said, "is that the price we have paid nationally for that preëminence has been a grave degree of nervous tension, restlessness, dissatisfaction with the results even of success, all pointing to our great need of the deep, quiet satisfactions of the inner life which are the antidote for these unhappy states." Putting in a good word for the "fads and frills" of education, Dr. Hullihen urged that for the sake of mental health, "our educational program, while continuing to give the training essential to the continued progress of the civilization to which we have already contributed so much, should give far greater emphasis through school

and college to creative activities, such as music, poetry, the plastic arts, and the other pursuits of beauty."

The challenge to the modern school, according to Dr. Fowler, arises not from what it does not do well, but from what it does not do at all, and among these things is its neglect of the child's emotions. "As a unique human personality, he simply does not exist," he said. "His behavior is something to be rewarded or penalized, but not to be understood. His mental health, which means his ability to live with others and himself, is still a closed book to all but a minority of the millions of parents and teachers who are responsible for child development in America. This is the real challenge in the public and private schools of America." If we are to train children for life, he concluded, we must give them every possible chance, in the family, in the Scout troop, in the church, and in the school, to live normal, happy, useful lives now; to benefit from the discipline of their own actions, from the guidance of wise teachers who themselves have learned how to live, and from a program of activities so varied, rich, and real that adulthood will mean merely the extension of a stable childhood.

Speaking in the same vein, Dr. Washburne said that we do not succeed in educating our children for the social life for which the traditional curriculum was nominally intended, "and we scarcely touch the child's own individual life, for which there is no curriculum." Mental hygiene, he said, is not a frill added on to a fundamental education, but is itself the basic foundation for all education. "Until our schools are organized in the light of mental hygiene and until expert mental-hygiene service is made available for children, teachers, and administrators, our schools will fail adequately to educate for life."

In a critical appraisal of mental-hygiene progress, Dr. Plant held that we are still largely in the "area of segregation," comparable to that in which the infectious diseases were treated by isolation, before the sanitary sciences launched their preventive attack on the sources of infection. We are not going to have real prevention, he said, "until we are working in the family, in the school, in industry, and in our political framework toward the amelioration of those conditions which give rise to these stresses."

A plea for greater attention to the gifted child, "as part of our national program for the conservation of natural resources," was made by Dr. Zorbaugh, who analyzed the problem presented by the defective provision in our school systems for this group of "exceptional children." Recent research, according to Dr. Zorbaugh, has shown up the errors in prevalent opinion which assumes that highly talented

children, despite their creative brilliance, or perhaps because of it, are physically frail, emotionally unstable, and socially inadequate. On the contrary, he said, they tend to be big and strong and well-coördinated, with excellent life histories, perhaps more stable emotionally than average children, socially inclined, well liked by other children, and typically leaders in their social groups. Nevertheless, he said, educators and mental-health workers are concerned about them because a large proportion of gifted children, when they reach adulthood, are not as productive as they might be. Society is not realizing what it should from these children. "We, as a nation, are scandalously dissipating and wasting the resources represented by our gifted children," he declared. "We spend annually millions on the feebleminded, with little hope of return, yet we invest little if anything in our gifted children despite the fact that we might certainly expect an immeasurably rich return from such an investment. These children have an enormous contribution to make, in intellectual achievement and leadership, if they can realize their possibilities."

Other speakers at the conferences included: Dr. M. A. Tarumianz, Superintendent, Delaware State Hospital; Harry V. Holloway, Ph.D., State Superintendent of Public Instruction of Delaware; J. E. W. Wallin, Department of Mental Hygiene, Delaware Board of Education; F. V. DuPont, President, Delaware Society for Mental Hygiene; Dr. George H. Preston, Maryland Commissioner of Mental Hygiene; Maurice A. Bigelow, Ph.D., Teachers College, Columbia University; Dr. Walter S. Cornell, Director, Medical Inspection of Public Schools, Philadelphia; Dr. Earl D. Bond, Director, Mental Hygiene Institute of the Pennsylvania Hospital; Dr. Camilla M. Anderson, Secretary of the Pennsylvania Mental Hygiene Committee; Rt. Rev. Msgr. John J. Bonner, Superintendent of Parochial Schools, Philadelphia; Olive Ely Hart, Ph.D., Principal, Philadelphia Girls' High School; Robert G. Bernreuter, Ph.D., Pennsylvania Department of Public Instruction; Frank Cody, LL.D., Detroit Board of Education; Professor Gilbert L. Brown, Northern State Teachers College, Marquette, Mich.; Professor Charles H. Judd, University of Chicago; Dr. Grover C. Penberthy, President, and Dr. Henry A. Luce, Medical Director, the Michigan Society for Mental Hygiene; Rev. Frederic Siedenburg, S.J., University of Detroit; Maude E. Watson, Ph.D., Director, Child Guidance Division, Children's Center, Detroit; Professor Howard Y. McClusky, University of Michigan; Edna Noble White, Ph.D., Director, Merrill-Palmer School, Detroit; Dr. George S Stevenson, The National Committee for Mental Hygiene.

Ninety-third Annual Meeting of the American Psychiatric Association

Over 1,300 of the country's specialists in nervous and mental disease attended the Ninety-third Annual Meeting of the American Psychiatric Association, which was held in Pittsburgh from May 10 to 14.

The meeting was marked by the advancement of new theories and conceptions of epilepsy, which throw further light on the biological bases of the disease and hold new promise for its eventual cure and control. The latest formulations are based on findings from recent researches into the electrical and chemical activities of the brain and nervous system, which were described by various investigators at joint sessions of the Association's Section on Convulsive Disorders and the American Chapter of the International League Against Epilepsy.

Dr. William G. Lennox, of Harvard University, said there is abundant evidence to indicate that the predisposition to epileptic seizures is a "fundamental and inherent, though recessive quality"; that the epileptic is but one of many who possess the epileptic gene; and that in the presence of a given stimulus, such as birth injury or cerebral infection, the predisposed individual will have seizures, while the unpredisposed will not. "There is evidence," Dr. Lennox continued, "that the genes are chemical substances, each gene consisting, perhaps, of a single large organic molecule. In the end, we must eliminate this molecule or learn to alter its chemical structure. It is a tantalizing thought that the replacement of, say, a potassium for a sodium ion in a certain molecule, the total bulk of which for all persons living would not be larger than a mustard seed, would eliminate epilepsy from the race. However, we are like elephants set to repair a wrist watch. Our minds are too small and our hands too huge for successful tinkering with the ultra-microscopic wheels of life. But the fact that genes can be altered by exposure to X-ray, even though this has a mutilating effect, gives a shred of hope that some day, in some generation, a way will be found."

A more immediate objective, Dr. Lennox said, was the elimination of seizures for the individual sufferer. He pointed out that it was now an established fact that these seizures were a disturbance in the normal rhythm of the electrical activity of the brain and that such disturbances could be moderated by certain alterations in body chemistry. To accomplish this, he said, the process which causes "irritability" must be known and controlled. Dr. Hallowell Davis, associate of Dr. Lennox, in a further interpretation of the electrical activity

of the brain, regarded the brain mechanisms in epilepsy as merely extreme variations of the mechanisms of normal brain functioning, and suggested that the characteristics of the "epileptic personality" may be of importance in determining the significance of normal individual differences in the electro-encephalogram. (The electro-encephalogram is to the brain what the cardiogram is to the heart.)

Dr. Herbert H. Jasper and Dr. Ira C. Nichols, of Providence, R. I., presented the results of their study of the "Berger waves" (electrical emanations from the head) of a group of epileptics. These showed, they said, that it would become necessary to revise our conception of the brain as an "intricate network of pathways and switches" by which an impulse which starts at the sense organ is finally conducted to its destination, and to consider it to be in "continuous, spontaneous activity," the sensory impulses arriving there being "thrown into a pool of dynamic excitatory processes that form the basis for the electrical brain waves which can be recorded." The electro-encephalogram, or chart of the brain waves, has been proven of value, they said, in the diagnosis of over four hundred cases of epilepsy, sometimes revealing the epileptic brain-wave pattern in individuals not suspected of epilepsy, and showing that confused mental processes, irritability, impulsiveness, and stubbornness are associated with potential changes in the brains of border-line convulsive states.

Reporting on a long-term study of the mentality of a group of epileptic patients, Dr. Joseph L. Fetterman and Dr. Margaret Barnes, of Cleveland, said that they found little deterioration, and expressed the opinion that such personality problems as were encountered among epileptics were caused by the social and psychological reactions to the disease rather than by any change in intelligence. Adequate training and sheltered workshops were suggested as possible means of combating these disorders.

In this connection, Dr. Lennox had previously pointed out that while the "seizure" was common to all epileptics, the mentality might range from that of a college professor to that of a helpless imbecile, and that no state has made adequate provision for these various types of sufferers. Despite the fact that half a million Americans now suffer from epilepsy (as many as suffer from active tuberculosis or diabetes) there are at the present time only four places in the United States where special investigations in this field are being financed—Chicago, Johns Hopkins, Yale, and Harvard. About 40,000 epileptic patients are now in state hospitals, occupying about 10 per cent of the beds in mental institutions at an annual cost of some $12,000,000, while only from $12,000 to $15,000 a year is available for research. Attempting in a small way to advance scientific work in this field,

Dr. Lennox hit upon a novel fund-raising plan which may commend itself to other enterprising practitioners—namely, the addition of a surcharge of 5 per cent to the bill of each patient he treats, for research promotion. In a printed notice accompanying the bill, he tells his patients of the urgent need for further investigation of the diseases for which they have been treated, and solicits the percentage of the bill as a voluntary contribution toward this purpose.

Favorable results in the treatment of epilepsy through the use of the so-called ketogenic diet were reported by Dr. Henry F. Helmholz and Dr. Moe Goldstein, of the Mayo Clinic in Rochester, Minnesota. Their patients were a group of 501 children who had been under treatment since 1922, 92 of them having been diagnosed as symptomatic epileptics and 409 as idiopathic epileptics. Follow-up studies showed that 30 per cent of the patients with idiopathic epilepsy were rendered free from attacks and 17 per cent were definitely improved, when the ketogenic diet was given an adequate trial; while of those with symptomatic epilepsy, 11 per cent became free of seizures following the use of this diet.

Dr. Laslo Kajdi, of Johns Hopkins Medical School, and C. V. Taylor, of Springfield State Hospital, described the use of a drug known as methylene blue in the treatment of epileptic convulsions. The drug, which is injected intravenously while the patient is in coma, has been employed on epileptics at the Springfield State Hospital during the past two and one-half years, with encouraging results. The paper reported the outcome of its use on 26 occasions in a group of six children and sixteen adults, as follows: on 14 occasions (54 per cent) attacks ceased, consciousness returned, and confusion was absent; on seven occasions (27 per cent) attacks ceased, but there were varying periods of subsequent delirium or fever; while on five occasions (19 per cent) this therapy failed. It was stated that this is the only method known to the authors which has the effect of causing the immediate return of consciousness, and this form of treatment was recommended as worthy of general use in "status convulsivus."

New discoveries in the localization of cerebral functions, which may upset previous conceptions in the identification of brain areas, were reported by Dr. Leland B. Alford, of St. Louis, as a result of recent surgical operations in which large sections of the brain, including nearly the entire right hemisphere in some cases and large parts of the cortex in others, were removed without the expected loss of mental capacity. Both positive and negative evidence, based on surgical, clinical, and pathological studies, said Dr. Alford, "definitely implicates a quite small area, lying posteriorly near the base of the brain, as being the one responsible, when injured, for 'clouding,

confusion, and dementia.' No other part of the brain, when injured, produces similar impairment of the mental faculties."

Dr. Alford characterized these findings as "extraordinarily far-reaching" in their implications, because, for one thing, they challenge the importance hitherto attached to the cerebral cortex (the proverbial "seat of human intelligence") in connection with mental processes and related functions, and, for another, "we may have been searching all these years in the wrong spots for the anatomical changes of mental disease, such as epilepsy and similar disorders." Again, "what is known as the frontal-lobe syndrome in which changes of character and loss of intellectual capacity were attributed to tumors in the frontal lobe, may not be of frontal origin at all, since surgical removal of these lobes has been unaccompanied by the expected findings." As a result, Dr. Alford said, "the basal structures of the brain, particularly those of the left side, now take on added significance and many readjustments in accepted conceptions become necessary." That the remainder of the brain may complement, complete, and intensify the functions of these basal left-side structures, he added, does not alter the fundamental conclusion.

Further therapeutic advances in the field of mental disorders were described, notably those following the use of "insulin shock" in schizophrenia. Dr. Manfred Sakel, of Vienna, discoverer of this form of therapy, supplemented his earlier reports with a new paper on the results of his method, which further substantiated his claims with regard to dementia-praecox cases and indicated the usefulness of the treatment in other types of mental disease, such as manic-depressive psychoses, compulsion neuroses, and hysterias. Encouraging results have been obtained in all these types, Dr. Sakel reported, but at present there are not enough cases on which to base definite conclusions. In his latest report he presented a dramatic picture of the "topography of the mind" as disclosed in his analysis of the disease process and its modification in the patients he has observed during the course of treatment. His discoveries in this new territory of "psyche's labyrinths" may help to determine what happens in cures or remissions in these cases under the influence of insulin therapy, the workings and effects of which on the mental process are still shrouded in mystery. Other papers described the results secured from the application of Dr. Sakel's method at various psychiatric centers in this country. All reported favorable findings in many of their cases.

Continued progress was also reported in the treatment of paresis, which was considered incurable up to fifteen years ago, when Wagner-Jauregg introduced his malarial-fever therapy. Since then improved

results have been achieved with various drug therapies, alone or in combination with fever, among them tryparsamide, which was used in a group of 511 patients treated at the Philadelphia Hospital for Mental Diseases. Discussing the outcome in these cases, Dr. Robert A. Matthews showed that 13.3 per cent completely recovered, while 25.8 per cent improved in greater or less degree.

In his Presidential Address, Dr. C. Macfie Campbell, of Boston, diagnosed some of the mental factors underlying contemporary world disturbances. War, industrial strife, mob violence, and other manifestations of social disorder have their roots primarily in the tensions and dissatisfactions of the individual life, Dr. Campbell said, and it is these personal factors, in the last analysis, that endanger the "apparent equilibrium of modern society." The organization of our present industrial order, he continued, presents many difficult technical problems, but the most important general consideration is "that of giving reasonable opportunities for the satisfaction of the human needs of the individuals who compose the society."

In order to do this, Dr. Campbell stated, it is necessary to know something of the needs of the individual, as well as the resources of the community, and in this way, psychiatry, by studying the basic conditions underlying the symptoms, can contribute something of value.

In speaking of international discord, Dr. Campbell remarked that there was no single aspect of it so startling as the mass destruction of war, because of conflicts as to beliefs or material possessions. "Yet war is a commonplace," he added, "and it is accepted by some as if it were an inevitable condition of human existence on this planet—as if human nature had some ineradicable tendency bound to express itself in recurrent outbursts of mutual destruction."

In this connection Dr. Campbell recalled the recent appeal made by the Netherlands Medical Association, together with 340 psychiatrists from 27 countries, to the statesmen of the world, which urged self-analysis upon them and declared that "if war is to be prevented, the nations and their leaders must understand their own attitudes toward war." "Could every statesman with impunity," he asked, "carry through a relentless self-analysis? What cabinet could stand if the self-knowledge of its members were pushed beyond a certain point?" Unfortunately, "the statesman is deeply committed to certain beliefs and activities; he is entangled in a mesh of action and belief of his fellows from which his very prominence may make it impossible to detach himself; and he may be immune to a rational appeal which lays such stress on self-knowledge." Instead of having departments of war, Dr. Campbell suggested, nations should have

departments of peace. Peace, like charity, he said, should begin at home. Peace of mind for the individual must be attained before there can be hope of peace among nations. The human soul is an area of conflicts between appetites and ideals, between childish and mature desires, between reaction and progress.

"A large part of man's waking time is passed in work," Dr. Campbell continued. "Many of his satisfactions and frustrations are associated with his work; his beliefs, his customs, his code, his personal relations are conditioned by his work. In his study and treatment of the individual patient the psychiatrist has to study not only the fundamental biological components of the personality and the complicated balance of factors within the family circle; he has to weigh the satisfactions and frustrations in the wider social relations, among others the satisfactions which come from work.

"In his patients the psychiatrist may see the importance of lack of status, of a feeling of inferiority, of frustration, of self-expression, of dehumanized personal relations, boredom, envy, depressive preoccupations. When these responses of the individual life are subject to the astounding amplification observed in group phenomena, a community is divided against itself, labor unrest and class warfare take the place of friendly social coöperation. For the solution of these problems or for the amelioration of the situation, a clear grasp of the human factors is essential."

Dr. Campbell represented the psychiatrist as being in a position to provide a complex society with that "self-knowledge" which might be its safety. "A society which his undergone a mental catharsis through the painful process of self-knowledge," he concluded, "may be conscious of a certain stability and peace, and can establish its international relations on a frank and honest basis of good will and coöperation, and can meet animosities and jealousies with an understanding attitude which may encourage self-knowledge on the part of others."

In a timely paper on the present crisis in social relationships, Dr. Samuel W. Hartwell, of Buffalo, urged psychiatrists to assume the leadership in the fast-developing field of mental hygiene, lest "a new profession only loosely affiliated with psychiatry supply the rapidly increasing demand in this field of mental hygiene and early psychotherapy." The urgency and importance of their doing so, he said, is dictated by the logic of events, which point to an even more rapid utilization of mental-health principles in the management of social problems in the near future. In ten years he visioned the majority of our criminals and delinquents studied and treated in terms of mental hygiene, hundreds of thousands of teachers seeking

to mold school children into patterns of mental health, and millions of parents looking to the mental-hygienist for practical help in leading their offspring into a normal way of life. With "the whole world turning to psychiatry," it is imperative, he said, if this demand is to be met along safe and sound lines, that psychiatry take the reins into its own hands and undertake to furnish the neccessary guidance and leadership. "The question now is—and it is a very important question for the psychiatric profession—What is to be our part in this great movement of mental health? Is psychiatry to maintain its leadership, which will be more conservative, more productive, and, at least for the next generation, more useful than any other leadership that may develop or can develop within the present generation?"

Despite the false hopes and premature promises held out in the past by a propaganda that overpopularized and oversold mental hygiene, Dr. Hartwell declared that "the idea and practice of mental hygiene remain and grow and become more constructive, useful, and more health-bringing as our mistakes in theoretical thinking are corrected and conservatism again comes into its own, as it always has and always will in all branches of medicine." Psychiatry will never solve the problem of unsound instruction, he added, merely by condemning the thoughtless, careless, popularized newspaper type of psychiatric and mental-hygiene teaching, but it can effectively combat the effects of this by doing the teaching itself.

The solution of the problem lies primarily in the psychiatric training of the medical profession. With 50 per cent of the hospital beds in the United States occupied by mental cases, with half of the sixteen million people who consult physicians in the United States and Canada needing psychiatric help of some kind, and with only 2 per cent of these physicians practising psychiatry, it is obvious that effective management of the situation must wait on the more adequate training and equipment of the general practitioner in the principles and practices of mental medicine. Next in importance is the enlargement of institutional activities in the direction of better out-patient services, better training for social workers, and more extensive preventive and educational work along community lines. Finally, psychiatrists must give more of their time and attention to community and social planning, in view of the profound changes that are taking place in social relationships.

In this connection, Dr. Hartwell referred to the "literally hundreds of laws, federal and state, enacted within the past four years, which carry a direct or indirect psychiatric implication," notably those coming under the heading of social security. The execution of these laws, he said, is creating a demand for psychiatrists in new jobs and new

set-ups, and there are few psychiatrists who have had the proper training for them. Rapid social changes, he continued, are producing personal tensions in large groups of our citizens, with a resultant increase in the number of those who need therapy and institutionalization. It is significant that lawmakers and executives are turning to psychiatrists for advice as to how the laws should be written and enforced, and for predictions as to what effect the new social legislation will have on the mental adjustment of our people. "Will psychiatry," he asks, "have any part in the formulation of plans that will lead to the solution of the great problem of decreasing the number of children predestined to a life of unhappiness, disease, and failure that will be born? Shall we have anything to say as to how we as a nation may lay plans to prevent sudden and catastrophic changes in forms of government?"

The following officers of the Association were elected for 1937-38: *President,* Dr. Ross McC. Chapman, of Towson, Maryland; *President-Elect,* Dr. Richard H. Hutchings, of Utica, New York; and *Secretary-Treasurer,* Dr. William C. Sandy, of Harrisburg, Pennsylvania. The Ninety-fourth Annual Meeting is scheduled to be held in San Francisco.

State Society News

Connecticut

The drive for the creation of a new and independent state department for mental health, which the Connecticut Society for Mental Hygiene has sponsored during the past year, was the central theme of discussion at a luncheon that marked the Society's Twenty-ninth Annual Meeting, held in Hartford on April 7. Governor Wilbur L. Cross, who was the guest of honor, discussed the work of the special commission appointed by him "to study the laws and facilities for the prevention, treatment, and cure of mental disease and defect," and to bring in an organization plan. Stressing the importance of the preventive work "that is largely the function of this commission," he said: "You know that I stand behind this commission either as an independent set-up or as a part of the health department. I cannot repeat too many times over how necessary it is to prevent mental disease."

Speaking for the commission, Mr. C. A. Moser described its activities in detail and brought out the urgency of the need for a new department, a bill for which was introduced in the legislature and has been under consideration by the governor's committee on reorganization. It was pointed out that Connecticut has no coördinated program for dealing with its mental-health problems and no correla-

tion of the work of its various mental institutions. This bill is designed to meet that need. Another bill calls for an appropriation of $4,000,000 for the erection of a second state training school for mental defectives. "I hope," said Mr. Moser, "that the General Assembly will grant this $4,000,000 appropriation that we have asked for. With it we can do a job, and it will be a job that will reflect favorably upon the policies of our governor and of the state in general, because whether we do it now or whether it is done some time in the future, this thing has got to be done."

Dr. C.-E. A. Winslow, who presided at the luncheon, said, "This is the greatest opportunity for mental hygiene that has occurred since Beers founded the society in 1908. There is a chance to achieve these two major ends. We want a new state department of mental health . . . We want this bill as it came from the governor's commission; and we want the $4,000,000 . . . that Mr. Moser's commission has found essential."

Dr. Winslow recalled that the society was instrumental in bringing about the establishment of the present division of mental hygiene in the state department of health. "But we have always felt," he said, "that that was a temporary measure, that the problem of the program planning and direction of intramural and extramural work for the insane and the feebleminded could be carried on only through an independent state department. And it is that recommendation that has come to the legislature from the governor's commission."

Dr. Winslow complimented the society on its work and influence, remarking that the past year was the most significant in its long career, and that it now has the largest number of members in its history.

In his report as medical director, Dr. George K. Pratt outlined three new projects which the society is undertaking—namely, the organization of a training course for leaders of parent-education groups; an experiment in dramatizing mental hygiene for radio presentation; and a study of the possibilities for mental-health work in industry.

The following officers of the society were elected for the new year: *President,* Dr. C.-E. A. Winslow; *Vice-Presidents,* Dr. C. C. Burlingame and C. A. Moser; *Treasurer,* John R. Daniell; *Recording Secretary,* Dr. George M. Smith.

Illinois

Following a recent self-analysis of its achievements, activities, and needs, the Illinois Society for Mental Hygiene is reorienting its work and program in certain directions and seeking to step up its resources

and capacities for service in line with increasing demands. To implement the new program, especially in relation to the medical and psychiatric aspects of its work, the society has taken on a medical director in the person of Dr. Conrad S. Sommer, to supplement its present staff. This action was made possible through the coöperation and financial assistance of the local community fund. Dr. Sommer was appointed to the position on May 1. He is a native of Peoria, Illinois, and a graduate of the University of Illinois Medical School, class of 1931. Following an interneship in New Jersey and special training in pediatrics at the New York Post-Graduate Medical School, he served as resident psychiatrist at the University of Illinois Research and Educational Hospital and, since 1933, on the staff of the Institute for Juvenile Research. During 1936 he was also in the psychiatric department of the Loyola University School of Medicine Dispensary.

Kansas

"The mental-hygiene movement in Kansas has stepped out of its swaddling clothes and is developing into a robust adolescent," writes Dr. Bert A. Nash in the *Bulletin* of the Kansas Society for Mental Hygiene, in commenting on its annual spring meeting, which was held in Witchita this year and attended by over 500 persons. "In the history of the movement," he states, "we have never had such concrete evidence of the fact that people are becoming convinced that something can be done about our problems of emotional and mental ill health." Another important factor revealed by the convention is that "teachers and social workers particularly have found an avenue through which they hope to arrive at some help for the problems which confront them." Also attending the meetings were many parents "seeking a way to a more effective direction of their children, through a better understanding of their mental and emotional characteristics." In addition to these groups, a great many physicians, psychiatrists, and psychologists were present at the convention. All of which shows, Dr. Nash concludes, that mental hygiene is no longer associated with the problems of mental disease alone, but with the preventive and positive aspects of healthful living in the whole realm of behavior. "Through the creation of social agencies primarily concerned with assisting people generally to develop more healthful ways of thinking, behaving, and of emotional expression, the mental-hygiene movement will reach its goal of activity."

The following officers were elected for the coming year: *President*, Bert A. Nash, Ph.D.; *Vice-President*, Ralph Fellows, M.D.; *Treasurer*, J. Stanley Reifsneider, M.D.; *Secretary*, Wilbert Mueller.

Louisiana

Moves to revitalize the Louisiana State Society for Mental Hygiene were made at a reorganization meeting held recently in New Orleans, at which new plans for the development of the society's activities took shape. Preparatory efforts to enlist the interest and backing of related groups resulted in the active coöperation of local mental-hygiene organizations throughout the state, among them the Louisiana State University Mental Hygiene Society and the Mental Hygiene Section of the Louisiana Teachers Association. The society will seek to extend its affiliations with various other groups interested in advancing mental-health aims, such as the state conference of social work, the state medical society, parent-teacher associations, the bar association, and the departments of health, education, and public welfare. A state-wide membership campaign is under way to consolidate public and professional support of the society's program and to raise funds for its work. Charter members are asked to pledge themselves to support the society "with a modicum of money and a maximum of energy so long as it carries out faithfully and well the aims of The National Committee for Mental Hygiene—namely, the direction of our social scientific forces upon the problems of the individual and of society, to the end that by enriching life and fulfilling its fundamental needs, the evils of delinquency, criminality, insanity, personal inefficiency, unhappiness, suffering, social insecurity, and actual distress may be increasingly prevented."

The officers of the society are: *President,* Dr. J. A. O'Hara, President of the State Board of Health; *Treasurer,* Susie L. Lyons, Superintendent of Social Service, Touro Infirmary; *Executive Secretary,* Dr. Paul C. Young, Department of Psychology, Louisiana State University. As vice-presidents and directors, the society has some of the outstanding medical and lay citizens of the state.

Massachusetts

The Massachusetts Society for Mental Hygiene has embarked on a new project in the field of education, in which it has already done notable pioneering work. It is a project in clinical research, which has been made possible by a grant from the Hyams Trust, and which will seek to promote among teachers knowledge of the principles of mental health. After years of lecture work among public-school teachers, the society decided "to demonstrate in a practical way how the concepts of physical and mental hygiene can be integrated and made effective in a public-school system." The new undertaking will serve this purpose in two ways: It will provide the staff of the society with an opportunity to improve and enrich the content of their teach-

ing by clinical experience, and it will provide new ways and means to bring the experience gained in this work to the teachers of the state. The usual methods of the child-guidance clinic will be followed in this experiment, with two important modifications: It will be geared to the special needs of education, and it will deal with *all* the children, not merely problem children. The school system of Norwood, a suburb of Boston, has been selected as the center for the experiment, which will be conducted by a special staff, assisted by an advisory committee of experts in mental hygiene and education.

Missouri

New horizons for mental hygiene in Missouri are visualized as a result of recent developments reported in the June *Mental Health Observer*. For many years the mental-health interests of that state found organized expression in the activities of two mental-hygiene societies: the Missouri Society for Mental Hygiene, whose work was largely centered in St. Louis, and the Kansas City Society, a local organization supported in part by the Community Chest Fund of that city. Last winter a group of seventy-five representative individuals from all parts of the state gathered at Columbia, Missouri, to discuss plans for reorganization and to set up effective procedures to carry out these plans. This reorganization is now an accomplished fact. Under the new set-up there exists The Missouri Association for Mental Hygiene, which serves as a "central, unified society" functioning on a state-wide basis, in fact as well as in name. At the same time the Kansas City Society becomes a chapter of the "state federation"; the former Missouri Society for Mental Hygiene is reorganized as The St. Louis Society for Mental Hygiene; and local societies organized in other parts of the state also become chapters of the state association.

The first president of the Missouri Association for Mental Hygiene elected under the new reorganization plan was Dr. Dudley Steele Conley, Dean of the University of Missouri Medical School, and the first annual meeting of the association was held at State Hospital No. 1, at Fulton, on May 2. At this meeting reports and plans were submitted by the chairmen of the following committees appointed by President Conley to supervise the various activities of the association—education, publications, eleemosynary institutions, legislation, and organization. Besides the *Mental Health Observer,* the association has decided to publish a monthly news letter to keep its membership and constituent societies in closer touch with the more rapid developments anticipated in mental-hygiene work throughout the state in the future.

The following officers of the association were elected for 1937-8: *President,* Dr. Ralf Hanks, Fulton; *First Vice-President,* Dr. C. E. Germane, Columbia; *Second Vice-President,* Dr. B. L. Elliott, Kansas City; *Third Vice-President,* Dr. Paul Zentay, St. Louis; *Secretary-Treasurer,* Dr. Fred McKinney, Columbia. Dr. H. Meltzer, of St. Louis, continues as editor of the *Mental Health Observer,* the official organ of the association.

Hospital Survey for New York

The Hospital Survey of New York has completed its monumental task of studying the present and future requirements of the metropolitan area with regard to institutional and other community facilities for "the organized care of the sick." The survey was sponsored by the United Hospital Fund and carried out under the direction of Dr. Haven Emerson, Professor of Public Health Administration of Columbia University, with the collaboration of a special study committee headed by Dr. George E. Vincent, former President of the Rockefeller Foundation. More than 800 institutions and agencies, of which 329 are hospitals, were covered by the study, the first of its kind ever conducted in this country, which dealt with every aspect of medical service except private practice, and projected the health needs of the area for a generation hence, with a view to long-range planning. For the purposes of the survey, the metropolitan district includes New York City; Nassau and Westchester Counties in New York; Hudson, Essex and Union, and most of Bergen and Passaic Counties in New Jersey; and the tip of Fairfield County in Connecticut—an area with a population of about 11,000,000 to-day and with an estimated population of 18,000,000 by 1960.

What the study does essentially, according to Dr. Emerson, is to provide the basis for replacing the present haphazard growth of organized care of the sick with a correlated, systematic program looking to a more efficient and a more economical utilization of the area's present treatment facilities and the planning of adequate provisions to meet the expected needs of the next two decades. To this end the survey staff suggested, as its major recommendation, the creation of a permanent planning board to coördinate the activities of all hospitals, dispensaries, and other institutions and agencies that care for the sick in the metropolitan area. This and other recommendations were presented by Dr. Emerson at a meeting of the United Hospital Fund held at the Pennsylvania Hotel in New York City on April 28, when the first findings and conclusions of the survey were made public. Since then the Fund has published, in a 1,200-page volume, a comprehensive report of the survey, containing a description of the

institutions and agencies studied, with an analysis of their use and cost, and a consideration of plans for the future. Two other volumes will be released shortly, one containing a complete financial study of the situation, the other a summary of both the service study and the economic analysis.

Chapter XIX of the present volume deals with the facilities for the care of the mentally ill, based on a survey conducted by The National Committee for Mental Hygiene in coöperation with The United States Public Health Service. It discusses statistical trends in mental disease in the metropolitan area, hospital and out-patient arrangements, bed capacities, movement of patients, costs, etc. The report reveals, among other things, expectations of mental disease of 5.72 and 5.55 per cent, respectively, for males and females, based on calculations for 1930. That is to say, 1 of every 17.4 males and 1 of every 18.0 females in New York City at the time of their birth may be expected to be treated in an institution for mental disease in New York State some time during their lives. This is greater than the expectation for New York State as a whole in 1920, when the computation of state-wide rates showed an expectancy of 4.7 and 4.3 for each 100 males and females respectively.

The study shows a progressive increase in the rates of admission to mental hospitals from New York City in recent years—from 75.7 per 100,000 residents of New York City in 1920 to 81.4 in 1930 and 96.8 in 1935. In general the rates increased markedly in the youngest and oldest groups, the greatest percentage increase being in the age groups up to fourteen years. Beginning with the age group forty-to-forty-four years, the rates advanced from year to year, but the growth was especially rapid at the older age levels. Assuming that the state mental-hospital population will continue to grow at the rate that prevailed between 1925 and 1935, the report estimates that there will be 86,583 patients in New York state hospitals in 1950 who will have been residents of New York City at the time of their admission, and 132,996 in 1960. Such calculation, it is pointed out, does not take into consideration the potential growth of family care in years to come, or the possibility that developments in preventive and therapeutic psychiatry may lessen the incidence of mental disease. On this point the report states: "It is doubtful if the state hospital population will continue to grow with the same acceleration that characterized the period between 1925 and 1935. However, a continuous increase for some years is rather certain since admissions exceed the total of deaths and discharges each year. Comprehensive planning should provide for approximately the present rate of case increases until at least 1945."

The report shows 43 special hospitals for mental diseases in or almost exclusively serving the metropolitan area, and 10 general hospitals in which beds are assigned to mental cases. On May 1, 1936, there was a total of 43,012 beds for mental patients in these institutions—41,754, or 97.1 per cent, in mental hospitals, and 1,258, or 2.9 per cent, in general hospitals. Of the beds in mental hospitals, 88 per cent are in 11 state hospitals, 8 per cent in 2 county hospitals, and 4 per cent in 30 voluntary and proprietary hospitals.

There was a total of 53,579 patients from the metropolitan area on the books of mental hospitals of all types on June 30, 1935, according to the survey: in state hospitals, 48,523, or 91 per cent; in county hospitals, 3,724, or 7 per cent; in voluntary and proprietary hospitals, 1,332, or 2 per cent. These figures reveal an overcrowding of about 18 per cent in state and county hospitals.

Of the total number of mental defectives in New York City, estimated in 1934 at 72,262 (1 per cent of the total population as computed by the survey), present institutional facilities accommodate only a little more than 10 per cent. The report recommends that at least 20 per cent of the mentally deficient should receive institutional care. If the facilities continue to expand at the present rate, it estimates that there will be accommodations in 1950 for 16,500 patients, and in 1960 for about 26,700.

While a creditable beginning has been made in the development of psychiatric services in general hospitals in the metropolitan area, the report urges greater provisions of this character for the care of patients who do not require continued treatment in mental hospitals. Some 2,900 beds are recommended to meet the present needs in general hospitals in this area, or 1,650 more than the existing 1,250 beds. On the basis of the projected population figures, approximately 4,500 beds of this type will be needed in 1960. The report also recommends the decentralization of these services, with a wider geographical spread through all the boroughs of New York City, in place of the present concentration in Bellevue Hospital, which now serves the boroughs of Manhattan, Bronx, and Richmond.

Instead of enlarging the existing metropolitan state hospitals, some of which run from 5,000 to 7,000 capacity, the report advocates the construction of a number of smaller hospitals of, say, 1,500 to 2,000 beds, to relieve the present overcrowding and to provide for future needs. It also recommends the permanent retention of the Manhattan State Hospital on Ward's Island to care for certain types of patient who should not be transported to the other state hospitals, most of which are located at a considerable distance from New York City. Other recommendations call for the extension of psychiatric hospital

facilities for maladjusted children to all the boroughs of the city, and the further development of such facilities in the state hospitals serving the metropolitan area; the extension of family-care arrangements for mental patients as a further relief from the institutional burden; and the provision of more adequate training facilities to meet the need for increased psychiatric and other professional personnel.

Commission Goes to Germany to Study Family Care

The past year has seen a growing interest in the family-care idea as one answer to the problem of providing accommodations for the constantly increasing number of mental patients in an institutional system already overburdened by an excessive accumulation of cases for whom adequate care has been increasingly difficult. Dr. Horatio M. Pollock's recently published *Family Care of Mental Patients* shows the seriousness of the situation and reviews the experiences with family care, known also as the boarding-out system, which has been successfully developed in various European countries (notably at Gheel, Belgium, where it has been practiced for centuries) and, to a limited extent, in the United States.

In this connection, The National Committee for Mental Hygiene is sending a commission abroad this summer for a special study of boarding-out arrangements in Germany, as a basis for further planning and experimentation looking toward the promotion of similar arrangements on a wide scale in this country, "as a supplement to, and relief from, the heavy burden of institutional care." Only New York and Massachusetts have made any substantial efforts to establish family care in this country, and it is felt that the more intimate knowledge of the German experience to be gained through this study will provide a further impetus to the movement for the development of boarding-out systems in connection with American institutions. The study, which is made possible by a special grant from the Oberlaender Trust, will be carried out by Dr. Pollock and Miss Hester B. Crutcher, both of the New York State Department of Mental Hygiene. Dr. Pollock has studied the question for several years from every angle, and Miss Crutcher is director of the department's social-service division, under which the family care of mental patients has been extended and supervised in New York State.

Rockefeller Foundation Stresses Mental Health

An increasing emphasis on the field of mental hygiene is noted in the broad program of activities financed by the Rockefeller Foundation, as disclosed in President Raymond B. Fosdick's annual review. On its excursion into the "world of the mind," the Foundation spent

over two million dollars during 1936, $900,000 of which went for work in endocrinology, $75,000 for the study of sex problems, and $1,073,050 for a general program of research in genetics, child psychology, dementia praecox, and investigative work in psychology.

Why mental hygiene? asks Mr. Fosdick. "Because it is the most backward, the most needed, and potentially the most fruitful field in medicine to-day." Our "tragic" lack of knowledge in this field, he writes, "may be deduced from the economic, moral, social, and spiritual losses occasioned by the feebleminded, the delinquent, the criminal insane, the emotionally unstable, the psychopathic personalities, and—less dramatic, but far more widespread—the preventable anxieties, phobias, tantrums, complexes, and anomalous or unbalanced behavior of otherwise normal human beings." The Foundation has no illusion, he adds, that the complete answer to the problem of mental abnormality lies in any particular approach, nor is it looking for immediate results. "It is not a field intrinsically easy for the application of scientific method, nor is there an abundance of well-trained men to carry on the work. And yet, with all its difficulties, it is perhaps the most significant, as it is the most challenging, field in which modern medicine is engaged."

Defining the term "psychiatry," which, he said, comes closest to identifying the Foundation's present program in the mental-health field, Mr. Fosdick held that it must mean far more than the traditional interests of the clinical psychiatrist. "If it is to be truly comprehensive, it must range all the way from anatomy to psychology. It must deal with the function of the nervous system, the rôle of internal secretions, the factors of heredity, the diseases affecting mental and psychical phenomena—in brief, it must lay a factual foundation for what is often called psychobiology." Tremendous as the problem of mental disease is in terms of mental-hospital beds, the picture of the vast, though undetermined, number of hospital patients whose apparent bodily illnesses are the result or the concomitant of mental disorders, he said, "would expose even more vividly the discrepancy in our effectiveness against 'diseases of the mind' as contrasted with 'diseases of the body.' . . . Body and mind cannot be separated for the purposes of treatment; they are one and indivisible. Whether he will or no, the doctor's office is a confessional of spiritual as well as physical disability. 'Mankind's eternal cry is for release, and the physician must answer it with something more than a test tube.'"

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